

An exploratory study of support given to caregivers at non-profit organisations based  
in Cape Town, South Africa

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of the degree of Master of Social Science in Social Development

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#### **COMPULSORY DECLARATION**

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## **Abstract**

In this study, the researcher investigated the types of support available to, and needed by, caregivers employed by non-profit organisations (NPOs) based in Cape Town, South Africa. Semi-structured interviews were done with caregivers and caregiver supervisors from four different NPOs based in Cape Town. The interviews were done on a face-to-face basis and included mostly open-ended questions. 23 caregivers, including 2 male and 21 female caregivers, as well as 4 caregiver supervisors were interviewed.

Through qualitative data analysis using Tesch's approach (1990 in De Vos, Strydom, Fouché and Delpont 2002), it was found that caregivers were supported by the NPOs they work for. Caregivers had social support from other staff such as social workers, supervisors and other colleagues. The caregivers also had access to training facilities from their NPOs and from the National Association for Child Care Workers (NACCW). Moreover, three out of the four NPOs participating in the study had transport facilities for caregivers to take children to school and other places. The NPOs also organised occasional recreational activities for caregivers. Caregivers were dissatisfied with their salary level and other financial rewards were not common. All the NPOs tried to provide some form of counselling or listening service for caregivers.

The human rights perspective provided support to the argument that the State needs to fulfil the need for protection and care of children by supporting caregivers through training and funding. The ecological systems approach allowed a better understanding of how caregivers work within an existing social system where issues of social support interact with legal and practical aspects of their work, and how their work life influences their personal family life, and vice versa. The human needs approach provided insight into the types of support needed by caregivers to feel fulfilled in their work life and on a personal level. With regards to the support that caregivers need and want, the capabilities approach provided the basis to understand the issue of increasing skills and capabilities of caregivers by providing them with capacity building opportunities through on-site training, subsidising driving lessons and facilitating their work schedule to accommodate the NACCW training. The people

centred development approach was appropriate to this study as the aim was to understand the perspective of the caregivers regarding the support that they need in their work.

Most of the support available to caregivers was found to be highly dependent on the resources available to the NPOs each year. The findings indicated that for all caregivers to benefit from the same level of support, national government needs to recognise the contribution of the caregivers working in the non-profit sector in achieving national goals. The State needs to invest more into the capacity building of caregivers and provide clear guidelines and specific policies regarding the work conditions of caregivers working with children. Additionally, a civil society movement needs to be put in place to fight for better conditions of work for caregivers employed in the non-profit sector.



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## Acronyms

ADLs	Activities of Daily Living
CBO	Community Based Organisation
CCG	Community Caregiver
CHW	Community Health Worker
CSO	Civil Society Organisations
DOT	Directly Observed Therapy
FETC	Further Education and Training Certificate
HCBC	Home Community Based Care
HIV / AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
HWSETA	Health and Welfare Sector Education and Training Authority
NACCW	National Association of Child Care Workers
NGO	Non-Governmental Organisation
NPO	Non-Profit Organisation
OVC	Orphans and Vulnerable Children
SACSSP	South African Council for Social Service Professions
SANGOCO	South African National Non-Governmental Organisation Coalition
SAOSWA	South African Social Workers' Association
SAQA	South African Qualifications Authority
UNISA	University of South Africa
US	United States
USAID	United States Agency of International Development

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University of Cape Town

## **1. CHAPTER 1: INTRODUCTION**

The role of caregivers in non-profit organisations working with vulnerable groups, such as the elderly, the sick, the poor and children, is undeniably critical for the non-profit sector to reach out to people in need. The work of caregivers has been widely demonstrated in research done in North America (Qualls and Zarit 2009; Ho, Collins, Davis and Doty 2005; Cain, Maclean and Sellick 2004), Europe (Da Roit, Le Bihan and Österle 2007) and South Africa (Ferreira, Keikelame and Mosaval 2001; Ferreira and Brodrick 2001).

However, little research has been conducted in South Africa on the support caregivers have in their work and the support that is needed but not provided. It is thus important to focus on the challenges faced by caregivers and to look at the role of NPOs in providing support to their caregivers. Such information will help to determine the responsibilities of the stakeholders of the non-profit sector towards caregivers. NPO management boards and government stakeholders can be better informed about the different services caregivers provide, the degree of professionalism involved in the work of caregivers, and most importantly the type and level of support that is needed for caregivers to work in proper conditions.

This study focuses on caregivers working for non-profit organisations (NPOs) in Cape Town, South Africa. It provides additional evidence on the tasks of caregivers and the role played by NPOs in supporting their caregivers as employees.

### **1.1 Background**

Providing care, or caregiving, has been practised in families and communities as a way of attending to the sick, the old and young (Cameron, Coetzee and Ngidi 2009). However, with the increase in prevalence of diseases such as HIV/AIDS (Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome) worldwide and due to family breakdown and dispersion, caregiving has come to be institutionalised in various parts of the world, namely in Europe, North America and parts of Australia (Guberman 2009).

In South Africa, the high HIV/AIDS prevalence among the population along with the increase in cost of care has led to an increase in the demand for caregivers for ill people (Cameron et al. 2009). Additionally, hospitals are not able to cope with the demands for beds and thus transfer the burden of patient care to NPOs and family care (Cameron et al. 2009). However, because the cost of living has increased and most adults in a family need to work to support the household, it has become difficult for family members to have time take care of older and sick family members (Cameron 2009). Therefore, families and individuals have caregivers to whom they are not related.

For people who cannot afford the services of a paid caregiver, the Department of Health (2012) of the Western Cape government has made provision for free medical services to many groups of people, among which is 'children who have been placed in care' and 'people receiving social grants', including the very sick and elderly. Such services might include foster care and home based care.

Home Community Based Care (HCBC) refers to "the provision of comprehensive services including health and social services, by formal and informal caregivers in the home" (Department of Social Development, Department of Education and Department of Health 2004: 8). The Department of Health (2012) further indicates that HCBC is basically providing quality health services at the home of the beneficiary and in communities to support people's health. This implies providing people with healthcare services at their homes and assisting them in their activities of activities of daily living (ADLs) so as to facilitate their well-being.

Although the Department of Social Development has provision for social workers and social development practitioners who provide services directly to the public, the Department of Health (2012) states that HCBC services in Cape Town are mainly provided by NPOs. There are 69 NPOs dealing with the care of vulnerable children in the Western Cape alone (Department of Social Development 2010). This confirms Mabin's (2002: v) statement that the non-profit sector is "vital to social development in South Africa". The Department of Health (2012) and the Department of Social Development (Republic of South Africa 2001) of the Western Cape also have regulations regarding training of community care workers who provide HCBC to people of the Western Cape. Indeed, the Department of Health (2012) funds the

training of community care workers which is accredited by the South African Qualifications Authority (SAQA). The Department of Health (2012) also indicates that it is aware that there might be hidden costs for NPOs in the process of employing and training of the community care workers or volunteers.

The regions in which the NPOs operate, and the target population that they work with, are among the poorest and most vulnerable people of Cape Town. Therefore, the work of caregivers is much more challenging given that they work with NPOs that have very limited resources.

## **1.2 Rationale of the study**

The assistance from caregivers is a necessity for individuals who cannot take care of themselves due to either illness, physical and/or mental handicap, age, or emotional state. Caregivers exist to facilitate better living conditions for others in society and they give enormous time and energy to achieve this goal. As a consequence, caregivers working within NPOs face challenges that are beyond those of the average office worker. Indeed, caregivers who work directly with people and try to assist the latter in their activities of daily living (ADLs) face up to issues such as dealing with symptoms of chronic or terminal illnesses, family breakdowns, violence, group or individual conflicts, alcoholism, drug abuse, and various other human challenges, on a daily basis. The work of caregivers involves exposure to situations far more stressful and anxious than the average human being.

As such, people whose work involves taking care of others need more and different support than any average worker (Guberman 2010). Therefore, it is necessary to determine the support structures in place for such individuals and the support structures that would be needed to improve their work life balance.

Moreover, although studies done in Europe and North America have examined factors which motivate caregivers to be committed to their work and the support that they get (Drentea, Clay, Roth and Mittelman 2006; Van den Heuvel, De Witte, Stewart, Schure, Sanderman and Meyboom-de Jong 2002), less information (Ferreira et al. 2001; Ferreira and Brodrick 2001) is available on the type of support needed by caregivers working with few resources in disadvantaged communities of South Africa.

### **1.3 Significance of the study**

This study explores the types of support that exist for caregivers working for non-profit organisations in Cape Town. By having more information about caregivers and the work they do, as well as the challenges they face, stakeholders of the social service professions, such as the Department of Social Development of the Western Cape and NPOs dealing with care patients, will have more insight into the daily realities of caregivers working for NPOs. Moreover, this study is from the point of view of the caregivers and the NPO directors and/ or care managers. Thus, this study may help to indicate the type and extent of support that presently exists for caregivers in Cape Town and may lead to recommendations into what needs to be done to support caregivers more effectively in their work environment.

### **1.4 Research questions**

1. What type of support do NPOs currently provide to their caregivers?
2. How does the support presently given to caregivers (by NPOs) impact on their work?
3. What are the challenges faced by caregivers working with NPOs?
4. What type of support do caregivers need from NPOs to do their job well in the long run?

### **1.5 Research objectives**

1. To determine the type of support that is currently provided to caregivers by NPOs.
2. To determine the relationship between type of support given to NPO staff and the impact on their work in the NPO, by comparing information from respondents.
3. To identify the challenges faced by caregivers working with NPOs based in Cape Town.
4. To identify types of support that is needed by caregivers to perform better in the long term.

## **1.6 Clarification of concepts**

### **1.6.1 Non-profit organisations (NPOs)**

The non-profit sector or not-for-profit sector refers to “organisations which are neither profit-making nor part of government” (Mabin 2002). According to the Non-Profit Organisations Act (No. 71 of 1997), an NPO is a “trust, company or other association of persons established for public purpose; and the income and property of which are not distributable to its members or office bearers except as compensation for service rendered” (Republic of South Africa 1997: 2). Therefore, in South Africa, “any organisation that is not for profit and is not part of government can apply for registration as an NPO” through the Department of Social Development (2010: 11). Examples of NPOs are non-governmental organisations (NGOs), community-based organisations (CBOs), faith-based organisations and any other companies, trusts and voluntary associations that are not-for-profit and NPOs are also referred to as civil society organisations (CSOs) (Department of Social Development 2011).

Swilling and Russell (2002) refer to five main characteristics of NPOs. These characteristics include that the NPO is:

- organised and institutionalised in terms of having a structure, goals and regular activities;
- private, namely being separate from government although the organisation can receive government funds;
- self-governing such that the organisation decides of its own activities and is not controlled by government or private organisations;
- non-profit distributing, in that any profit made by the organisation is reinvested into the activities of the organisation; and
- voluntary, implying the organisation is expected to have volunteers participating in its activities and management.

### **1.6.2 Caregivers**

There are different definitions of the term caregiver and a variety of roles linked to it. For instance, while the term ‘caregiver’ is more commonly used in North America,



other English-speaking countries such as the United Kingdom, Australia and New Zealand, prefer the term 'carer' (Guberman 2010). According to Cameron et al. (2009: 100), other terms for caregivers or community care workers are "Community Caregiver (CCG), Community-Based Health Worker, Home-Based Carer, Ancillary Health Care Worker..." These terms imply that the caregiver does healthcare delivery related work in the community but may not be qualified professionally as a healthcare worker (Cameron et al. 2009).

Cameron et al. (2009:100) state that CCGs have been recognised for their efforts "in empowering people with health care knowledge and facilitating access to Primary Health Care (PHC) services" by the healthcare sector when the World Health Organisation's (WHO) Alma Ata declaration of 1978 focused on PHC. This opened up some of the pathways for formal and standardised training for CCGs (Cameron et al. 2009).

Additionally, there are different categories of caregivers depending on what the person does and the conditions of work of the caregiver. For instance, informal caregivers refer to people who are unpaid or family members of patients (Cain, Maclean and Sellick 2004: 265). Thus, formal caregivers are people who are paid or given a stipend to take care of patients.

#### **1.6.2.1 Caregiver roles**

In her assessment of the work of family caregivers, Zarit (2009) provides a checklist of activities performed by family caregivers. The activities include: personal care (for example, dressing, grooming, bathing and elimination), household care (such as taking care of meals, housekeeping, maintenance, repairs and shopping), finances (namely helping with bills and banking), communication (helping to answer the phone and write), and general activities (such as driving, staying alone, walking and conversation). As such, in the case of mentally ill patients and the elderly, caregivers assist patients in performing daily activities such as "getting out of bed, getting dressed, incontinence, bathing" and eating (Liu and Gallagher-Thompson 2009: 88). Caregivers are there as facilitator for ADLs, which includes important socialisation aspects such as helping the individual communicate with the outside world in various ways, participating in economic life, and moving around.

In short, caregivers are people who provide direct assistance to others and thus help the latter improve their living conditions. This study defines caregivers as formal caregivers, as they are described above, in that they receive a stipend and/ or salary for assisting people in their activities of daily living (ADLs).

### **1.6.3 Support**

People involved in caregiving work have demonstrated vulnerability to psychological distress and burden (Atienza, Collins and King 2001; Drentea et al. 2006; Liu and Gallagher-Thompson 2009; Van den Heuvel et al. 2002), as well as various other daily problems linked to their work as caregivers (Ho, Collins, Davis and Doty 2005). They therefore require support for themselves as individuals and as caregivers or care workers.

General definitions of support include the following: providing assistance; bearing the weight of something; providing people with basic needs (Dictionary Unit for South African English 2010), which relate to the support that is needed by people to have acceptable living and working conditions. With reference to the support given to, and needed by, caregivers, the definition of support needs to include aspects of assistance from organisations, such as NPOs and government. The support for caregivers can be in different forms, namely financial support, group support and individual support (Van den Heuvel et al. 2002), social network support (Drentea et al. 2006; Liu and Gallagher-Thompson 2009), and online support through self-help groups (Perron 2002). These are explored further in the literature review.

This study centres on the support given to caregivers by the organisation they work for and with. Therefore, for the purposes of this research, support refers to resources and other types of support given to care workers to assist them in coping with the challenges of their work environment, as well as the support that the caregivers think is required to help them further in their work.

## **1.7 Ethical considerations**

Ethical considerations provide guidelines and standards which a researcher can use as base to evaluate her conduct (Strydom 1998). Social researchers are required to be

ethical in the way they do research with human subjects by respecting “the rights to dignity” of respondents, avoiding any harm to the respondents, and work “with honesty and integrity” throughout the research process (Denscombe 2003: 134).

In the context of this research, it was necessary to gain such clearance as the respondents work with people who are from vulnerable groups such as children and in certain cases AIDS patients. Moreover, to be accountable to the Department of Social Development of the University of Cape Town and be in line with research ethics, the researcher applied for clearance from the ethics committee of the Department of Social Development of the University of Cape Town to do the research on human subjects, in this case caregivers and directors and caregiver supervisors of NPOs. The researcher gained the agreement of the Department of Social Development to approach non-profit organisations and their staff for research purposes, as well as obtained the permission from the NPOs to interview their caregivers and caregiver supervisors and directors.

The following research ethics (UCT Code for Research Involving Human Subjects 2011) were considered for this study:

### **1.7.1 Anonymity and confidentiality**

Before the start of the interviews, the researcher and each respondent entered into an agreement (a consent form was signed by both the participant and the researcher) to guarantee anonymity and confidentiality of the respondent and to ensure that the content of the recorded interviews were to be used for research purposes only. The researcher promised not to divulge the respondent’s identity (Heath, Brooks, Cleaver and Ireland 2009; Babbie and Mouton 2001). The mutual agreement between the researcher and the respondents ensured that participants know their rights to privacy and anonymity before the interviews. Also, when reporting findings, the researcher did not indicate any personal characteristic that could allow a reader to identify the respondents based on their answers during interviews (Engel and Schutt 2010). That is, the real names of respondents were not attached to specific statements within the research report and only the researcher knew who they actually were and to which organisation they belonged to.

### **1.7.2 No harm to the respondents**

During the research process there is potential for the respondents to “be harmed in a physical and emotional manner” (Strydom 1998: 25). When doing interviews, harm can occur when respondents are asked to reveal information that makes them feel uncomfortable, such as painful past experiences or deviant behaviour (Babbie and Mouton 2001). It is the responsibility of the researcher to prevent the respondents from harm by informing the latter of the purpose of the study before the interviews (Strydom 1998) and explaining that there are no ‘right’ or ‘wrong’ answers for questions asked. According to Strydom (1998: 25), the researcher “should have the firmest of scientific grounds if he extracts sensitive and personal information” from respondents.

Therefore, to protect the respondents from any harm during this research, the researcher shared the purpose of the study with respondents before the interviews and gave clarifications about ethical considerations for the interview and whole research process. Moreover, the interviews were done in settings familiar to the respondents so that they could feel more at ease and were thus more open to disclose their views and thoughts (Heath et al. 2009).

### **1.7.3 Informed consent and voluntary participation**

For respondents to voluntarily agree to be part of the research, they need to be given “all the information they need to decide whether to participate in a research study” and to be sufficiently competent to “understand what they have been told” (Engel and Schutt 2010: 43-44). This means that the researcher needs to explain the purpose of the research to the respondents and that the latter must be given “adequate opportunity...to ask questions before the study commences, as well as during the investigation” (Strydom 1998: 26). Moreover, respondents need to be able to “withdraw from the study at any time and also to withhold their data” if they wish (Huysamen 2001: 181).

In the context of this research, the respondents were informed by the researcher and by gatekeepers that the broad purpose of the study was to gather information about the support caregivers receive from the NPO they work for and the additional support that

would need. Additionally, the researcher obtained the agreement of respondents with regards to using a voice recording device during the interviews. The respondents were given the opportunity to confirm their voluntary participation verbally before the start of each interview and also signed a consent form (Refer to Appendix B). The respondents were told that they could withdraw their participation from the research at any point during the interview process.

#### **1.7.4 Deception and debriefing**

Deception can occur during research when respondents are misled about the true purpose of the research or about the identity of the researcher (Engel and Schutt 2010). Sometimes, the researcher may choose not to reveal the full nature or purpose of the research before data collection as it might lead to biased answers from respondents (Denscombe 2003). Nevertheless, the researcher needs to debrief respondents after the data collection process, namely by telling the latter about the true nature or purpose of the research and by clearing out all misconceptions the respondent may have about the whole research process. Debriefing is done to ensure that there is no or minimal psychological harm for respondents (Huysamen 2003; Strydom 1998).

In this research, it was not an issue for the researcher to tell respondents about the study objectives and the data collection process. The identity of the researcher and broad purpose of the study were shared with respondents before the interviews. The respondents were told that the information collected was for research purposes only and that the research might not lead to any change in their work and living conditions. The respondents were debriefed at the end of each interview session by being thanked for their participation and asked about their feelings with regards to the interview process. They were given the opportunity to express any emotions felt without judgement on the part of the researcher. This helped to address any feelings or issues the respondents had about the interview process.

#### **1.7.5 Analysis and reporting**

The researcher abided by ethical standards (UCT Code for Research Involving Human Subjects 2011; National Association of Social Workers 1999) when analysing the

information collected and writing the research report. That is, the researcher compiled the research report as accurately and objectively as possible to make sure the information it includes is understandable by readers and reflects the reality of the findings of the study (Babbie and Mouton 2001; Huysamen 2003; Strydom 1998). Any shortcomings or errors were stated in the research report to encourage the use of the study by others (Strydom 1998).

The researcher analysed the interview transcripts in a neutral manner, so as to have as little influence as possible with regards to the themes that emerged from the information collected. To avoid bias in the information presented in the research report, the researcher included all findings. The research report is adequately referenced and limitations of the research are included.

Moreover, the researcher intends to give feedback to respondents and participating NPOs on the research findings after the final research report is rated by examiners. A summary of findings will be made available to all respondents through the NPOs.

#### **1.7.6 Competence of the researcher**

It is the responsibility of the researcher “to ensure that they are competent and adequately skilled to undertake the proposed investigation” (Strydom 1998: 30). This means that the researcher needs to consciously abide by ethical rules and guidelines during the whole research process, from the selection of the research population and sample to the writing up of the final research report (Strydom 1998). The researcher also avoids value judgement by respecting the respondents and their cultural, social and economic context (Strydom 1998).

The researcher interacted with respondents when doing the interviews during the data collection process. The researcher made sure she informed the respondents of the purpose of the research, of her identity as a student researcher and of the whole research process. The data collection process involved interviews with respondents who did not have English as a first language. In such cases, the researcher made sure she understood the words perfectly by sometimes having the respondents repeat their answers.

### **1.7.7 Authorship and cooperation with collaborators**

Strydom (1998) advises for all parties involved in the research process to enter into a contract so as to be clear about their share of contribution to the research and therefore be acknowledged in the research report. This is necessary to avoid misunderstandings after the research is published or made public.

In the final research report, the researcher acknowledged and thanked all contributions from persons who have helped in some way during the research process, namely respondents, caregiver supervisors, facilitators, gatekeepers and all others who have made the research possible. Respondents were thanked anonymously for the sake of confidentiality and the NPOs participating in the research were also thanked.

### **1.8 Reflexivity**

According to Denscombe (2003: 300), “reflexivity concerns the relationship between the researcher and the social world.” This means that the researcher cannot be entirely objective during the research process as everything the researcher knows and “the concepts the researcher uses to make sense of the world” also come from the socially constructed world (Denscombe 2003: 300). Nevertheless, reflexivity is a tool that can be used during qualitative research to acknowledge that the researcher has influence over the research processes. Indeed, reflexivity is also a tool to analyse how the researcher influences the research (Finlay 2003). By acknowledging the influence of the researcher on the research processes through reflexivity, the researcher remains self-conscious about the effects she may have on respondents, on the information collected, on the data collection instrument that is developed and on the research findings and reporting (Denscombe 2003).

During this study, the researcher constantly thought about the different research steps, namely on:

- the research methods used and the implications for both the respondents and the research process;
- the data analysis process with regards to the themes emerging and connections between them;

- the ethical issues and standards such as the concerns of the researcher's values and biases and responsibilities to respondents; and on
- emotions, biases and assumptions that might arise from contact with the respondents and their contexts (De Vos, Strydom, Fouché and Delpont 2011; D'Cruz and Jones 2004).

The different stages of the research process were constantly discussed with the supervisor so as to review any assumptions made and avoid bias. This whole process is documented and reflected in the research report.

Qualitative research implies much more personal involvement by the researcher throughout the research experience as opposed to qualitative research which is just as demanding on the researcher but which can be done in a more detached manner from the research participants. Janesick (2004) refers to the researcher experiencing serendipity as part of the reflection process when analysing data collected. That is, unexpected incidents or occurrences that may provide information that contributes to the research. The point is that the researcher involved in qualitative research needs to be open to the influence of intuition, informed hunches and serendipity and welcome the unknown and unexpected.

## **1.9 Structure of research report**

### **Chapter 1: Introduction**

The introduction chapter provides the background to the research problem which is to find out about the support that is provided and needed by caregivers working for NPOs based in Cape Town. The rationale and significance of the study is given and the main research questions and research objectives are outlined. Definitions of key concepts are provided and ethical considerations observed during the research are outlined.

### **Chapter 2: Literature review**

The literature review provided information about caregivers and caregiver support from previous research done on the topic. Elements that are covered include the status of caregivers in South Africa, policies pertaining to caregivers in South Africa, the



role of the non-profit sector in caregiving in South Africa, the work life of caregivers, the patient-caregiver relationship, the challenges faced by caregivers and models of support for caregivers. Theoretical frameworks are also used to provide further understanding of caregivers and caregiver support.

### Chapter 3: Research design and methodology

The research design and methodology chapter describes the approach to research used for this study, namely a qualitative one. The different steps of the research process are outlined and explained, namely how the researcher gains entry to the caregivers and NPO directors/ caregiver supervisor for the research, how the sample of participants is chosen and the procedures and methods for data collection. This chapter explains the process of data analysis and verification. Limitations of the study are also provided.

### Chapter 4: Findings and discussion

The findings of the study are outlined in a tabular form, indicating main themes and categories that have emerged from the data analysis. The themes and categories are linked to the main research questions. Each theme and its subsequent categories are described and discussed.

### Chapter 5: Recommendations and conclusion

This last chapter provides recommendations that address the issues discussed in chapter 4. The recommendations are directed to NPOs who employ the caregivers, to the non-profit sector as a whole, to the State, to specific government departments, to caregivers and to the broader community.

## **CHAPTER 2: LITERATURE REVIEW**

This chapter presents a review of the literature on the work done by caregivers and the challenges that caregiving work involves for the caregivers. Although the focus is on caregivers in South Africa, studies done in Europe and America are also cited. Policies relating to the work and status of caregivers in South Africa are described. Theoretical perspectives, namely the human rights perspective, the human needs approach and the ecological systems approach, are used to further understand the needs of caregivers and to understand the impact of external and internal factors on the work life of the caregiver. Further theoretical perspectives, such as the capability approach and the people-centred development approach are used to indicate the way forward to improve the support system for caregivers in South Africa.

### **2.1 The typical caregiver**

Following a review of research studies on caregivers, done in the United States and Canada since 1980, Prachakul and Grant (2003: 56) define caregivers as “persons primarily responsible for assistance with either activities of daily living or instrumental activities of daily living.” Their definition is in line with Zarit’s (2009: 115) definition of the primary caregiver, as being “the person who has taken on the responsibility of care for the patient.” Zarit (2009) goes on to say that the primary caregiver can be a family member or whoever has taken the responsibility of the person in need of care.

Likewise, the National Alliance for Caregiving and American Association for Retired Persons (NACAARP) (2004) describes the typical female American caregiver as having some college experience and spending at least twenty hours per week providing unpaid care to an elderly person. The NACAARP (2004) also indicates that a caregiver is usually a relative or a friend who voluntarily takes care of the patient. The NACAARP (2004) states that the caregiver is usually qualified to have another paid job, but may only be working part-time due to time spent providing care. A survey done by the Commonwealth Fund Biennial Health Insurance company in 2003 in the United States (US) indicated that there was 16 million informal caregivers aged from 19 years to 64 years in the US and 2 million informal caregivers aged over 65

years (Ho et al. 2005). The survey also indicated that two-third of the caregiver population was female.

However, in the case of people who have been neglected by family members or who do not have a next of kin due to being migrants or orphans, it is often an NPO that steps in and provides staff to take responsibility to take care of them.

In the context of a training project for caregivers in South Africa, namely the Thogomelo project, the Department of Social Development (2011) gathered data on community caregivers in South Africa. The information collected indicates that 90.3% of community caregivers are women and that 50.4% of them are aged from 26 to 40 years (Department of Social Development 2011: 5). 57.8% of community caregivers are single, 43.4% have at least a matric certificate and 89% of community caregivers receive a stipend of about R1000 per month from the NPO they work with (Ministry of Social Development 2011: 5). Such information provides a picture of the typical caregiver in South Africa as being a mid-aged female with a low education level and poor revenue.

The Children's Act No. 38 of 2005 (Republic of South Africa 2005: 19) defines a caregiver as "any person other than a parent or a guardian who cares for a child". This definition of caregiver applies to "(a) a foster parent; (b) a person who cares for a child with the implied or express consent of a parent or guardian of the child; (c) a person who cares for a child while the child is in temporary safe care; (d) the person at the head of a child and youth care centre or other children's facility where the child has been placed; (e) the person at the head of a shelter; (f) a child and youth care worker who cares for a child who is without appropriate family care in the community; and (g) the child at the head of a child-headed household." The Department of Health (2010: 85) also applies the definition of caregiver as per the Children's Act (No. 38 of 2005) and add that a caregiver can also be defined as "a person who is caring for someone who is ill." The above-mentioned definitions of a caregiver can be said to cover all types of caregivers, whether they are family members, formally employed by families or within institutions or informally providing care. The definition also highlights that there is not one typical description of a caregiver, as circumstances for each patient vary largely even within countries, such as in South Africa. However, most definitions of caregivers include two aspects,

namely that care work is being done and the persons receiving care have physical, mental, age-related or other limitations that prevent them from accomplishing certain activities alone (Guberman 2010).

## **2.2 The status of caregivers in South Africa**

Schneider, Hlophe and Van Rensburg (2008) studied caregivers in the South African context. They described the increase in the number of caregivers since the mid 1990s as being linked to an increase in budget allocations for HIV related programmes. Schneider et al. (2008) focussed on caregivers described as community health workers (CHWs), and including lay workers such as home-based carers, lay counsellors and Directly Observed Therapy (DOT) workers. From 2004 to 2006, Schneider et al. (2008) made a series of visits to 16 primary health care facilities in Gauteng and conducted inventories of CHW numbers and training, as well as two facility-based group interviews with a total of 413 CHWs, and interviewed of clinic nurses who supervised CHWs. Their study concluded that there were a significant number of caregivers in the South African healthcare system and that a strengthened healthcare system was needed to sustain caregivers in their work (Schneider et al. 2008). Such findings implied that many caregivers were untrained and lacked professional qualifications for the job they were doing.

The South African government has made provision for different categories of workers involved in social and care work in the Social Work Amendment Act (No. 102 of 1998). Indeed, the Social Work Amendment Act (No. 102 of 1998) stipulates that persons practising professions in the social care field, namely caregivers, require the establishment of a professional board representing caregivers to be registered and thus be legitimate to work in South Africa. Thus, caregivers require a professional board to be set up so as to get officially registered as formal caregivers and work within the amendments of the act.

In 2001, an Advisory Board on Social Development Act (No. 2 of 2001) was passed providing the platform for a professional board for caregivers to be set up. The Advisory Board on Social Development Act (No. 2 of 2001) also served to provide a “national advisory structure in the social development sector with the aim of building and consolidating partnerships between government and civil society...” Thus, the

legislative framework was set for civil society to work with the government in healthcare service delivery.

In 2005, the National Association of Child Care Workers (NACCW), a NPO, was successful in establishing a professional board for child and youth care workers, also known as caregivers who work primarily with children and youth (The International Child and Youth Care Network 2005). The NACCW (2011) provides professional training for these caregivers, as well as the infrastructure to promote healthcare and development of children and youth in South Africa. The NACCW has developed training programmes for aspiring child and youth caregivers in South Africa.

The Social Service Professions Act (No. 110 of 1978) and its subsequent amendments, regulate the registration of social workers and other social service professionals for which professional boards have been established. However, not all caregivers are registered with professional boards such as the NACCW.

The legislation has been implemented to make provision for aspiring professional caregivers at different qualification levels. Firstly, for people without any academic education background or previously disadvantaged learners, there is a Further Education and Training Certificate (FETC) in child and youth care work which is presently offered and accredited by the South African Qualifications Authority (SAQA 2012). The NACCW South Africa has also developed specialised courses for caregivers working with children and youth at risk (The International Child and Youth Care Network 2005). At a tertiary education level, the NACCW South Africa has developed a degree course in child and youth care work in partnership with the University of South Africa (UNISA) and the Durban University of Technology (The International Child and Youth Care Network 2005).

The South African Minister of Social Development, Ms Bathabile Dlamini, has indicated that the department's 2011 budget made provision for the recruitment and training of 10000 child and youth caregivers over the next three years (Dlamini 2012; Sabinet Law 2011). Minister Dlamini has indicated that the newly trained caregivers would help to attend to the situation of child headed households and that they will work according to the Isibindi model developed by the NACCW of South Africa (Sabinet Law 2011). This expansion of the Child and Youth Care Services (CYCS)

was further confirmed in June 2012 through the Department of Social Development's job creation initiatives programme which includes a focus on child and youth care workers (Parliamentary Monitoring Group 2012).

### **2.2.1 Conditions of work of caregivers**

In the case of caregivers working in South Africa, the Basic Conditions of Employment Act (No. 75 of 1997) and its subsequent amendments apply. Basically, the act provides details about hours of work and annual and sick leaves. Caregivers can work up to 45 hours weekly unless a signed agreement allows for 15 hours daily. There is provision for a collective agreement between employer and employee that enable work hours to be averaged over a period of up to four months. Caregivers working at night, between 6.00 p.m. and 6.00 a.m., should be compensated or there should be a reduction of their working hours. Transport needs to be available in that case. The act states that caregivers who work after 11.00 p.m. and before 6.00 a.m. the next day need to be informed of health and safety risks involved in the job and they have the right to undergo a medical examination. Caregivers are allowed six weeks paid sick leave per period of three years and twenty-one consecutive days of annual leave. Annual leave can be reduced by the number of days the caregiver takes occasional paid leaves. Section 15 of the Act declares that daily and weekly rests period for employees should be of at least twelve consecutive hours between the ending and the recommencing of work, unless the employee lives on the premises.

### **2.3 The role of the non-profit sector in caregiving**

Chesteen, Helgheim, Randall and Wardell (2004) undertook a study to compare the quality of care provided in non-profit and for profit nursing homes. Chesteen et al. (2004) reported no direct link between non-profit status of the nursing home and the quality of the care provided, where the quality of care was measured according to percentage of patients with bedsores and frequency of medical care. However, the study found that the process quality (which refers to operational processes of the nursing home such as management procedures, degree of teamwork and patient focus) was higher in non-profit nursing homes than in for-profit nursing homes, although the degree of patient's disability was lower in non-profit nursing homes (Chesteen et al.

2004). Chesteen et al.'s (2004) study showed that the NPO sector can be efficient in supporting the healthcare sector.

With regards to the status of caregivers in South Africa, the non-profit sector has been very active in implementing legislation and assisting government in furthering welfare goals. Although the contributions of the NACCW have been noted, less information is available on the extent to which NPOs sustain the health and social service sector, and the number of caregivers that operate within NPOs. Cameron et al. (2009) referred to the NPOs, CBOs and family carers as bearing the costs and burdens of healthcare because public hospitals are inadequate and private healthcare is expensive.

Swilling and Russell (2002: 27) reported that there were 6517 NPOs operating in the health sector and 22755 NPOs operating in the social service sector. These two sectors involve work in areas such as child welfare, care of the elderly, health services and care of mentally ill patients (Swilling and Russell 2002). More recent statistics indicate that there are 81476 voluntary associations, which include CBOs, and 2163 non-profit companies and 1839 trusts, which include NGOs (Statistics South Africa 2013: 22). However, there is no clear information about the number of formal and informal caregivers employed within those sectors in South Africa.

## **2.4 Patient-caregiver relationships**

Besides the activities involved in taking care of patients, the caregiver may also be involved in “emotional support..., behaviour management, supervision of rehabilitation exercises, meds and other treatments, mobilisation and advocacy for services and other resources, mediation with various professionals, control of the quality of the care, decision-making for the patient...” (Guberman 2010: 3). Indeed, the work of caregivers is far more complex and demanding than just providing care. Depending on the type of patient and on the specific needs of the latter, caregivers have different roles. For example, in the case of a child patient, the caregiver may also have the role of parent to the child. Caregiving also involves an element of human contact from the physical care provided to patients to the emotional and social support involved in the relationship with the patient. A caregiver to an elderly person or to a terminally ill patient may become the friend and confident of the person facing death. Thus, caregiving demands skills in various areas of life.

According to Guberman (2010), it is important to take into account the context in which caregivers work when reflecting on the quality of care provided. The type of relationship that the caregiver builds with the patient also determines the quality of care (Guberman 2010), such that home care is more likely to result in forming closer ties with the patient as compared to patients being cared for within an institution.

A study by De Schipper, Riksen-Walraven and Geurts (2006) demonstrated how the child-caregiver ratio is an important factor in the quality of the interaction between the child and the caregiver. De Schipper et al. (2006) observed 217 caregivers from 64 child care centres in the Netherlands. Observations were done during two structured play episodes, where each caregiver was once with a group of three children and for the second episode with a group of five children. The findings indicated that a 3:1 child-caregiver ratio allowed for a higher quality interaction between the children and the caregiver than the 5:1 child-caregiver ratio. As the quality of the caregiver's behaviour improved when dealing with a smaller group of children, the well-being of the children in the smaller group improved as well. Although the research was done in Netherlands, the findings might indicate that the child-caregiver ratio is a determinant factor in the quality of the work environment caregivers and might influence the level of support they need in the work place.

## **2.5 Challenges faced by caregivers**

Studies about formal and informal caregivers reflect various aspects of the lives of caregivers and the issues they face within their work environment and in their personal lives. Such issues are health problems, including physical and mental breakdown due to overload of activities and burnout, financial problems and gender issues (Guberman 2010; Ho et al. 2005; Prachakul and Grant 2003).

### **2.5.1 Health problems**

In their study which reviewed research done in the United States and Canada on informal caregivers of HIV/AIDS patients, Prachakul and Grant (2003) found a relationship between physical health of the caregiver and overload of work, financial worry as well as depression. Caregivers may experience adverse psychological reactions, disruption in their social support system, severe stress and depression



because they spend many hours working with minimal time for themselves and others (Liu and Gallagher-Thompson 2009; Lynch, Lyons and Cantillon 2009; Ho et al. 2005). An American study of the effects of caring for an elderly parent on the health of the caregiver showed that married male and female caregivers showed depressive symptoms over time (Coe and Van Houtven 2009). There was also evidence of increased incidence of heart conditions for single male caregivers. The study indicated that negative effects on physical health for married female caregivers appear two years after having worked as a caregiver (Coe and Van Houtven 2009). Ho et al. (2005) studied informal caregivers in the United States (US) and found that the caregivers experienced heightened anxiety levels when having to cope with personal health problems and caring for others. This was also linked to their lack of confidence in the previous US healthcare system (Ho et al. 2005).

Such studies refer to caregivers experiencing health associated problems due to different factors from their caregiving occupation impacting on their personal and social life. It is therefore clear that the healthcare needs of caregivers are a priority as one needs to be fit to take care of others. With regards to issues such as access to healthcare, which is a basic human right, the government, NPOs and other stakeholders can intervene at different levels to facilitate access to healthcare for caregivers.

### **2.5.2 Financial problems**

As indicated by Prachakul and Grant (2003), worrying about lack of money to meet ones needs is related to depression. Lack of money is an issue faced by many formal caregivers working with NPOs as they are often poorly remunerated and sometimes only get a stipend barely enough to cover transport cost and food cost. Guberman (2010) refers to three types of economic costs that can arise from caregiving, namely employment-related costs (such as low income level due and career opportunities forfeited to be a caregiver), out-of-pocket expenditures (such as expenditure on the patient and transport costs) and unpaid care labour.

### **2.5.3 Gender issues and work-life balance**

An evaluation of Home Community Based Care (HCBC) in Southern Africa found that about 91% of caregivers were women (Cameron et al. 2009) and in South Africa 90.3% of CCG are women (Department of Social Development 2011). Moreover, many studies have found that caregivers are more often than not family members of the patient (Ho et al. 2005; Perron 2002). This may indicate that women are the ones expected to take care of an ill family member, sometimes at the expense of their leisure time and their careers. Despite clichés about women bearing the burden of housework rather than men, it is a reality that in many households women are expected to do the housework (Lynch et al. 2009), as well as work full-time. In many poor households, women employed as informal or formal caregivers find it difficult to sustain a living (Cameron et al. 2009). A Canadian study by Ward-Griffin, Brown, Vandervoort and McNair (2005) analysed the experiences of women who work in the field of healthcare, namely nursing, medicine, physiotherapy and social work. Their analysis revealed that female health professionals who also carried out personal family caregiving had to constantly juggle their professional role and their family responsibilities. The study also revealed that despite a number of strategies adopted by the women to cope with both professional and personal duties many of the women experienced feelings of isolation and physical and mental exhaustion. However, it is not unlikely that both male and female caregivers may experience the feeling of having two families to take care of, one at home and one at work.

Moreover, Cameron et al. (2009) report that cultural norms in many parts of Southern Africa do not make it acceptable for young black women caregivers to take care older men and these cultural norms apply even for trained and registered caregivers. Also, when there is a male caregiver in a team, the latter may feel the need to assume the role of team leader simply because of being male rather than due to merit or leadership skills (Cameron et al. 2009). Thus, it is a challenge to be a female caregiver in Southern Africa.

### **2.6 Models of support for caregivers**

A number of studies have provided evidence which showed that supporting caregivers impacts positively on the work and well-being of the caregivers. A study done by Van

den Heuvel et al. (2002) used a control group and intervention groups to determine the long term effects of a support programme on informal caregivers of stroke patients in the Netherlands. The support programme included “expressing emotions, receiving information and learning how to use active coping strategies” (Van den Heuvel et al. 2002: 292). The research concluded that, in the long term, the intervention groups reflected “small to medium increase in confidence in knowledge and the use of an active coping strategy” (Van den Heuvel et al. 2002: 291).

A study by Navaie-Waliser, Feldman, Gould, Levine, Kuerbis, and Donelan (2002) with a random sample of 1002 informal caregivers in the US reported on the possible adverse effects of not providing support for caregivers. According to Navaie-Waliser et al. (2002), caregiving is a work that requires preparation and support. Otherwise, this might result in a “stressful and potentially unsafe environment for the caregiver and the care recipient” (Navaie-Waliser et al. 2002: 409). Therefore, this indicates that lack of preparation and support to face the challenges of caregiving can lead to problems for both the caregiver and the patient.

There are various ways in which caregivers can be supported.

### **2.6.1 Financial support**

The study of Da Roit et al. (2007) on the care policies of Austria, France and Italy indicate that many governments have recognised the importance of financing care and creating social assistance for specific categories of people who require a caregiver. The aim of doing this in these countries was to increase the likelihood that the elderly, the sick and children in distress have an income to cater for a registered and trained caregiver (Da Roit et al. 2007). Indeed, a study of informal caregivers by Ho et al. (2005) in the US indicates that the cost of caring for a person is too much for the unpaid carer to handle. According to Ho et al. (2005), the informal caregiver is usually a family member who faces issues such as unemployment, missing work due to caregiving, and lack of personal health coverage due to money issues.

Although some of these country policies for welfare provision were not successful (Da Roit et al. 2007), they do indicate that the government is being responsible for the care of its population.

According to the Social Assistance Act (No. 13 of 2004), the South African government provides the following social grants to specific categories of children:

- a care dependency grant covering children (aged 0 to 18 years) who have a severe disability and require full-time and special care;
- a foster child grant for people taking care of a child who has been placed in their custody through court order; and
- a child support grant for children of destitute families.

In the case of the care dependency grant, it is to be noted that the role of the caregiver can be held by the child's biological or foster parents, or a family member, without any specific training in caregiving for children with special needs.

The Social Assistance Act 2004 further indicates that the government provides an old age pension that amount to R1200 per month as from 12 April 2012 for citizens who are 60 to 74 years old, and R1200 plus R20 for those aged 75 years and above (South African Government Services 2012). Given the cost of living in South Africa and the existing inequality in distribution of wealth, it is quite challenging to believe that this amount is sufficient for an average elderly person to pay for the services of a caregiver if needed.

The point is that the services of caregivers are usually poorly remunerated or not at all paid in South Africa. The government does not make sufficient provision people in need to access the services of caregivers. Thus, the work of caregivers is often free, out of goodwill, or it is meagrely supported by NPOs. Despite an existing debate about the dependency of the South African population on grants, there is no justification for not making provision for the elderly, children and the disabled to have access to care.

### **2.6.2 Educational and skills development – The Thogomelo Project**

The Thogomelo project is a support structure available for caregivers in South Africa. It is actually the first accredited training course for designed for community caregivers in the country (International HIV/AIDS Alliance 2012). The training focuses on psychosocial support and child protection and aims to improve the quality

of care provided to children who are victims of HIV and AIDS, and/ or face poverty, abuse and neglect.

The South African Department of Social Development (2011) has joined the United States Agency for International Development (USAID 2012b) in the Thogomelo project, initiated in 2008, to help the caregiving sector. The aim was to provide support for community caregivers to address the needs of OVC through caregiving, as well as support existing projects and structures involving caregivers and link activities of civil society and the public sector (Department of Social Development 2011; USAID 2012b). USAID has helped to fund and give structure to the 'Thogomelo Psychosocial Support and Child Protection Skills Development Program for Community Caregivers' which aims at building the capacity of community care workers working with HIV positive patients, their families and AIDS orphans (USAID 2012b). For the implementation phase, the International HIV/AIDS Alliance (2012) partnered with Health and Development Africa and PATH, an international NPO, to make the Thogomelo project a reality on the ground.

So far, 113 community caregivers from Mpumalanga province have gone through the programme and their training has been endorsed by the Health and Welfare Sector Education and Training Authority, a skills development authority in the health and social development sector in South Africa (USAID 2012a; HWSETA 2012). Additionally, in March 2012, the Mpumalanga community caregivers graduated after successfully completing the Thogomelo programme for South Africa (International HIV/AIDS Alliance 2012; USAID 2012b).

### **2.6.3 Social support**

Social support for caregivers is about having a social system, consisting of counsellors, support groups and other caregivers, with whom the caregiver can communicate and share emotions felt in the process of caregiving as well as find information about the patient's condition (Drentea et al. 2006; Spiegel and Kimerling 2001). Drentea et al. (2006) described the importance of social support for caregivers of spouses with Alzheimer disease. Although their study focused on informal caregivers, it indicated that having a social support system was beneficial to the caregivers in their personal and work life (Drentea et al 2006).

In a study by Roth, Mittelman, Clay, Madan and Haley (2005), 312 spouse caregivers were provided with counselling and support intervention and then structured interviews were done to assess the change in social support and psychological outcomes experienced by the spouse caregivers. Results of the latter study indicated that there were mediated effects from the social support network on the depression and stress level experienced by the caregivers. This indicates that caregivers' psychological state can benefit from a social support network intervention.

With regards to a work environment, where caregivers are attached to an NPO or an institution, social support can also be of benefit. This was demonstrated through a study about providing support to staff of a nursing home to increase staff retention in the long run (Riggs and Rantz 2001). The staff support model included addressing the needs and assumptions of staff and patients of the nursing home through personal and group activities, identifying the roles played by each individually and in groups, and defining the relationships between individuals and groups within the nursing home (Riggs and Rantz 2001). This support model required an administrator and human resource person to be effective (Riggs and Rantz 2001).

In South Africa, resulting from its unique melting pot of people, various legislation and policies have included local terms (such as Ubuntu and Isibindi) that reflect values such as social solidarity, social cohesion and social support. These local terms indicate the values which the policies are trying to promote in the population.

#### **2.6.3.1 The Ubuntu principle**

Ubuntu is a term used in South Africa and expresses the idea of acting for the common good for society and humanness (Venter 2004). This expresses the idea that a person is linked to others and can recognise himself or herself in others. In the context of welfare Ubuntu means to care for each other (Bak 2004). The White Paper on Social Welfare (Republic of South Africa 1997) describes the Ubuntu principle as "the principle of caring for each other's well-being...and a spirit of mutual support... Each individual's humanity is ideally expressed through his or her relationship with others and theirs in turn through recognition of the individual's humanity. Ubuntu means that people are people through other people." Through the Ubuntu principle, the government is saying that it cannot eradicate poverty alone but needs the support

and cooperation of the population (Bak 2004). The responsibility of welfare in the country needs to be shared with the population as well.

Orner (2006) demonstrates this in her study with primary caregivers of people living with AIDS in South Africa. Findings indicated that caregivers saw the health sector as supportive when they received information about how to care for patients and when they received encouragements about their work (Orner 2006). This means that as these caregivers help the hospital patients with follow-up care, they are also helping the health sector and the health sector supports them mutually.

Similarly, when welfare policies are implemented in the form of social grants for the population, the idea is for the State to provide resources to take care of its population and the State also expects people to be humane enough to take care of people who are not covered by the policies. Moreover, the underlying meaning of the Ubuntu principle in the White Paper on Social Welfare of 1997 is that a strong mutually beneficial partnership between the government and civil society is needed to achieve full welfare among the population.

#### **2.6.3.2 The Isibindi model**

Another local term used in South Africa is Isibindi which literally means liver in the Zulu language but symbolically refers implies ‘courage’ (Dlamini 2012; Friedman 2005). With support from the departments of Education and Social Development, the National Association of Childcare Workers (NACCW) has developed the Isibindi model which is a “support programme for childcare workers based on the ‘Circles of Support’ concept of that Khomanani campaign” (Friedman 2005: 178). The Isibindi model was designed to train and support caregivers working directly with child-headed households and communities where HIV/AIDS is rampant (Sabinet Law 2011).

The Khomanani campaign emphasises on the theme ‘caring together’ with regards to the context of HIV and AIDS (Department of Health 2003). Basically, the concept of ‘Circles of Support’ is about channelling social assistance to orphans and vulnerable children (OVC) and their families (Department of Health 2003). Thus, the Isibindi model is about the creation of a social and community support system for OVC and other youth and children of South Africa.

Dlamini (2012) describes the Isibindi model as focussing on keeping OVC siblings together by working with communities which have high rates of HIV and AIDS prevalence. The Isibindi model also involves training young people as caregivers to provide HCBC for children through youth empowerment and child protection programmes (Dlamini 2012). Sabinet Law (2011) reports that the Department of Social Development has focused resources on training caregivers according to the Isibindi model to specially attend to the needs of children in child-headed households in rural and informal settlements.

#### **2.6.4 Online support**

Although online support may be perceived as social or community support, it is described separately as it does not involve human contact between the online helper and the caregiver seeking support.

A study by Perron (2002) describes an online self-help group for caregivers of mentally ill patients. Although the study found that many caregivers were family members, therefore informal caregivers, it is interesting to look at the mechanism involved in the online self-help support group. Indeed, this online platform “...provided an opportunity for family and friends of the people with mental illness to describe their lives, tell about traumatic events and share emotions” (Perron 2002: 75). Perron (2002) also reports on the therapeutic benefits for caregivers because they were able to respond and comment almost instantly online. Another study involved an in-home online support system where the caregivers communicated via email to seek support (Pierce, Steiner and Govoni 2002). Pierce et al. (2002) studied an in-home online support for caregivers of stroke patients. The findings indicated that caregivers used the online support mainly to find medical information about caring for survivors of stroke (Pierce et al. 2002).

However, Perron (2002) reports that online support has setbacks because of the limits to express emotions and non-verbal language online. Also, online support presupposes that the caregiver has access to electricity and the Internet and knows how to use a computer. This is a challenge for caregivers who are not used to new technology.



### **2.6.5 Psychological support**

Mittelman (2005) writes about the need for psychological support for caregivers in the form of psychosocial or psychiatric interventions. After a review of studies on health issues faced by caregivers and mental problem experienced by the latter, Mittelman (2005) stresses on the importance of providing psychological support for caregivers as part of the intervention package which supports persons in need of care. That is, according to Mittelman (2005), providing care to the caregiver is essential. A study by Botsford and Rule (2004) demonstrated how a six-week psycho-educational group intervention with 27 mothers, acting as caregivers, of aging adults with developmental and mental disabilities resulted in increased knowledge about planning for the future.

## **2.7 Theoretical frameworks**

To gain further insight into the challenges faced by caregivers, the needs of caregivers and the support that is available to caregivers, a set of theoretical frameworks are used. Thus, the human rights perspective provides further understanding of the status of caregivers in South Africa as providers of healthcare services. The ecological systems approach provides a holistic understanding of the macro and micro factors that contribute to the challenges faced by caregivers in their work. Max Neef's scale of fundamental human needs provides insight into the human needs of caregivers. The capability approach then provides the platform to express how the opportunities and life choices of caregivers can be expanded. Finally, the people-centred development approach helps to provide insight into how caregivers as well as other stakeholders can contribute to improve the support system of caregivers.

### **2.7.1 Human Rights perspective**

The right to healthcare is part of basic socioeconomic rights of people to have access to quality health services to be able to live in good conditions (Cameron et al. 2009). Indeed, the Universal Declaration on Human Rights (United Nations 1948) states that individuals have inalienable human rights. In line with this, the Constitution of the Republic of South Africa (1996) refers to the right to equality of treatment before the law (Section 9), the right to human dignity, and the right of access to healthcare services (Section 27). This means that basic services such as healthcare, which are

fundamental to human survival and welfare, are guaranteed by the South African Constitution. It is, therefore, the responsibility of the government to guarantee the delivery of quality healthcare services for everybody in the country. This is of vital importance for people who cannot afford private and paid healthcare.

Moreover, the White Paper for Social Welfare (Republic of South Africa 1997) follows the principle of Ubuntu and includes provision for policies and programmes that provide access to care and support for every person in South Africa, especially the most vulnerable groups which are children, the elderly and women. This implies increasing access to healthcare services by addressing the issue of lack of trained staff in the healthcare sector and creating an environment supportive of the most vulnerable groups of society.

Thus, for children in South Africa, the Welfare Laws Amendment Act (No. 10 of 1997) makes provision for a child support grant, a care dependency grant and a foster child grant to support the growth, well-being and development of children. The Children's Act (No.38 of 2005) refers to principles about the care and protection of all children in South Africa. The Children's Act also includes specifications about the role of caregivers in the lives of the children placed in their care. Section 32(1) of the Children's Act (No. 38 of 2005) specifies that a person, who has no parental rights to a child, such as a caregiver, but who cares voluntarily for a child, needs to care for the health, well-being and proper development of that child, and needs to protect the child from abuse, harm and neglect. Additionally, the Child Care Act (No. 74 of 1983) includes regulations for the treatment of children who are placed in special care institutions. Both the Children's Act and the Child Care Act have been amended to fit the context and needs of today's children.

However, the above mentioned legislations, namely the Children's Act (No. 38 of 2005) and the Child Care Act (No. 74 of 1983) do not provide indications about the rights and welfare of caregivers at work.

Minister Dlamini of the Department of Social Development has stated that under the amendments of the Children's Act (No. 38 of 2005), there is specific provision for adult supervision of child-headed households where the eldest child is above 16 year old. However, in cases where the eldest child is under 16 years old, Minister Dlamini

states that it is the responsibility of the Department of Social Development to create a supportive and protective environment for the children (Sabinet Law 2011). In line with this, the Department of Social Development is recruiting and training caregivers whose main role is to support the child-headed households (Sabinet Law 2011).

### **2.7.2 Ecological systems approach**

Bronfenbrenner (1979 in Pierson 2010) provided an ecological systems approach to human development showing how the micro system, mezzo system and macro system interact and influence each other. Thus, by taking an ecological approach of the situation of caregivers, one gets a holistic view of the how the different elements of society interact to create challenges for caregivers.

According to the ecological systems approach, the caregiver would be in the micro system which also includes the family, close friends and neighbours. The mezzo system includes the micro system, the extended family and wider circle of friends and also includes the immediate work environment of the caregiver. The macro system includes the mezzo system as well as the media, the wider economic system, the political system, the legal system and all other social and cultural values.

Thus, the caregiver interacts with and within the different systems and is mutually influenced by them. For example, a caregiver facing personal health problems will not be able to attend work regularly. The micro system affects what happens in the mezzo system, and vice versa, as shown by Prachakul and Grant's (2003) study, where overload of work (an element of the work 'mezzo' environment) was linked to the caregiver experiencing depression (an element of the micro system).

Thus, by influencing elements of part of the system, such as changing the conditions of work, this has effects on the caregiver, who is in the micro system. De Schipper et al. (2006) demonstrated how a child-caregiver ratio of three to one resulted in higher quality of interaction between the caregiver and the child as compared to a child-caregiver ratio of five to one. Through this study, De Schipper et al. (2006) changed an element of the work environment of the caregivers by decreasing the number of children a caregiver was responsible of. This change improved the caregiver's

behaviour in the work context and this correlated with the children's well-being and cooperation with the caregiver.

### **2.7.3 Human needs approach**

The human needs approach refers broadly to what people require for their holistic development. Examples of basic human needs are unpolluted air and water, housing, adequate food and physical and emotional security (Davids et al. 2009). In the context of this research study, Max Neef's (1991) scale of fundamental human needs is used to understand the needs of caregivers. The scale includes nine fundamental human needs which people have and which need to be satisfied for a person to experience well-being and full development. The nine fundamental human needs as described by Max-Neef (1991) are subsistence, protection, participation, affection, creation, leisure, freedom, identity and understanding. They are not linear or hierarchical in that any of the needs can be achieved before or after or simultaneously with any other. Max-Neef (1991) argues that they are universal and interdependent.

Therefore, for a caregiver to satisfy the need of subsistence, she/ he needs to have food, housing and work, needs to be physically and mentally healthy, needs to eat work, rest and interact with others in the family, work environment and society at large (Max-Neef 1991). Simultaneously, the caregiver might be fulfilling the need of participation while through interactions with the work environment and society.

Bailey and Paul (2008) carried out an evaluation of a five-week caregiving programme designed to meet the needs of rural caregivers of Alzheimer's patients. The programme was in the form of workshop sessions where caregivers and healthcare staff participated. The evaluation concluded that caregivers gained more knowledge about caregiving and felt more comfortable in their caregiving roles, thus fulfilling the need of understanding as per Max-Neef's scale. At the same time, the five-week programme allowed caregivers to participate and share with others, thus fulfilling the need of participation as well.

Furthermore, Max-Neef (1991) indicates that if a need is not satisfied, then this creates negative emotions that prevent the individual from experiencing well-being and development. O'Brien (2009) also distinguishes between authentic satisfiers and

pseudo- or inhibiting or singular satisfiers. While authentic satisfiers help to meet fundamental human needs in a sustainable and positive way, other types of satisfiers may only meet needs momentarily and may have negative outcomes for the individual, such as prevent other needs from being met.

Thus, in the case of a caregiver who becomes isolated because of spending a lot of time in-doors taking care of a patient, the caregiver is fulfilling the need of protection through being caring and helpful to the patient but might be prevented from experiencing personal leisure time. A caregiver might also develop strong and close relationships when taking care of patients and come to know more about the patient's condition, thus fulfilling the needs of affection and understanding. However, if caregiving work implies lack of time to participate in other social circles it will be a barrier to the need of participation.

In a US study focussing on the issue of staff retention in nursing homes, Riggs and Rantz (2001) proposed a model of support that allows for a supportive workplace that meets the needs of both the nursing staff and the residents of the homes. The study showed that having a workplace that allows the nursing staff to fulfil work roles as well as social roles enhances the nursing staff's satisfaction of social and professional needs, such as subsistence, understanding and participation, and hence promoted staff retention.

#### **2.7.4 Capability approach**

Sen (1999) adopts a freedoms approach to human development stating that the ultimate aim of human development is the access to freedoms. Sen (1999) describes freedoms as being what people need and want for their well-being, such as access to education, healthcare, social security, having one's rights respected and living in dignity, as well as being able to participate in society at different levels (economic, social and political). Sen (1999) also refers to 'unfreedoms' as being obstacles to human well-being, such as the disadvantages faced when living in a poverty stricken area or when being part of a minority group. Examples of 'unfreedoms' include famine, low life expectancy, long-term unemployment, lack of access to social security, to healthcare, to education and to clean water (Sen 1999).

Following Sen's (1999) approach to human development, Robeyns (2005) adopts a 'capability approach' to assess human well-being, thus helping in providing an indication of people's level of freedoms in different societies and at different moments in time. Similar to Sen (1999) who views different types of freedoms, Robeyns (1995) approach describes human well-being as multi-dimensional, indicating that it covers various factors (material, social, political, cultural and economic). Thus, as people experience more freedoms their capabilities or opportunities increase, giving them a wider choice of lifestyle. They are thus more likely to experience well-being.

In the case of caregivers, having support structures and mechanisms to deal with the various challenges they experience means that caregivers expand their capabilities in organising and coping with their daily activities. It is, therefore, necessary to determine the needs and wants of caregivers, regarding their work, so as to enhance their work life and ensure their overall well-being. By having an in-depth understanding of the challenges faced by caregivers and their needs, we are able to identify ways to remove the 'unfreedoms' that they face and expand their actual freedoms and thus give them a wider choice of lifestyles, especially with regards to their work life and how they deal with daily challenges.

In the world of caregiving, a way of increasing the capacities of caregivers and thus providing expanded possibilities is through capacity building. Evans, Ahmed, Day, Etse, Hua, Missani, Matola and Nyesigomwe (2004) have defined capacity building as going beyond the training of individuals, and as involving human development, access to knowledge and capacity to understand information and skills development. Evans et al. (2004) have tried to apply the best instruments and practices of capacity building to various population groups across cultures, including caregivers. They implemented the best capacity building practices and principles, namely building relationships, identifying and building on what motivates people, deepening knowledge and understanding, ensuring time for reflection, creating systems for monitoring and evaluation. Evans et al. (2004) tested these principles through small projects in areas of Uganda, Nigeria, Tanzania, Zanzibar and Malawi. Their research was conclusive in showing the effectiveness of capacity building for formal and informal caregivers.

In South Africa, despite measure by the government to regulate the status of caregivers and the participation of NPOs, the approach to supporting caregivers has often been prescriptive, rather than focussing on the needs and wants of the caregivers as expressed by the caregivers. The Department of Social Development (DSD) of the South African government is easing the process for caregivers to get access to training, through the NACCW, so as to build the capacity of caregivers. However, caregivers have not yet been able to express their needs and wants as to their conditions of work, as to the content of the training they need, and as to the type of status they want for the work they do.

### **2.7.5 People-centred development approach**

It is interesting to adopt a people-centred development approach to determine how caregivers can act upon making their ‘freedoms’ or opportunities become reality.

The people-centred development approach places emphasis on people as being the most important element of development (Davids, Maphunye and Theron 2009). Korten (1990: 76) defines people-centred development as “a process by which the members of a society increase their personal and institutional capacities to mobilise and manage resources to produce sustainable and justly distributed improvements in their quality of life consistent with their own aspirations.” Thus, people-centred development is about people mobilising to create their own development and well-being by making efficient use of resources.

Davids et al. (2009) refer to four building blocks of people-centred development, namely public participation, social learning, empowerment and sustainability. Participation, conscientisation, empowerment and sustainability are important elements of the process of becoming a caregiver. Public participation is the active involvement of the beneficiaries of the development process in the identification of the problem, in finding solutions and in the actual ‘doing’ of the implementation phases (Willis 2007). Thus, as caregivers determine their own needs and wants with regards to the challenges they face in their work life, this can bring about prioritisation of these needs and the formulation of solutions to address the needs. This was demonstrated by Ferreira et al. (2001) in their study of older women as caregivers to children and grandchildren affected by AIDS. The study included 43 grandmothers

from townships of Cape Town and involved 156 children in care. The caregivers were asked about their support needs as caregivers based on the difficulties they were facing. The Ferreira et al. (2001) study was followed by a pilot intervention project to support the caregivers (Ferreira and Brodrick 2001). The intervention project was a response to the needs expressed by the caregivers and was aimed at empowering them through capacity-building and information (Ferreira and Brodrick 2001). The caregivers participated in the design and implementation of the project through workshops and activities that were held in the pilot project process (Ferreira and Brodrick 2001).

The social learning process refers to how one learns to use resources to meet personal needs and the needs of the wider community. Davids et al. (2009: 20) refer to the using “oneself and one’s environment” in the process of meeting all needs. Thus, people-centred development arises from this process the individual is able to be an active part of the development process. Paulo Freire also adds the element of conscientisation that is present during the process of social learning (Davids et al. 2009). Conscientisation is seen as the awareness of the individual that he or she can make positive change happen. A trained caregiver is more aware of children issues and thus better able to face issues arising in the workplace. Fukkink and Lont (2007) did a meta-analysis of studies focusing on the caregiver training done between 1980 and 2005. Their analysis showed that specialised training in childcare does make a significant positive difference in the type of care provided by the caregiver. Moreover, Fukkink and Lont indicated that awareness of child issues through education, training and interaction with the children in the workplace does allow the caregiver to do a better job.

Another element of people-centred development is empowerment. Empowerment is about the person taking responsibility for their own development through the realisation that they exercise control on their own lives (Davids et al. 2009). Research by Burchinal, Cryer, Clifford and Howes (2002) focussed on the importance of education and training of caregivers. They found that caregivers going through formal or informal training both bring additional value to the child’s experience of caregiving. Their study included 553 infants, toddlers, and preschool centre classrooms, and they focussed on the association between classroom quality and the



highest level of formal education of the caregiver and whether the caregiver had attended workshops and other trainings. Burchinal et al. (2002) concluded that caregivers with formal education or informal education, namely training, were more sensitive to interactions with children, provided higher quality care than other caregivers, and children interaction with such caregivers had more advanced language skills. These findings indicate that an empowered caregiver, through education and training, does a better job.

Finally, sustainability refers to the fact that the process of change and development that takes place and meets the needs of the people in the present without affecting the ability to meet the needs of future generations (Davids et al. 2009). Riggs and Rantz (2001) study of a model of support for the work environment of nursing homes indicated that a people-centred work environment does help retain staff in the long term. This implies that organisation supporting its caregivers with trainings and workshops adds value to the work done by the caregivers and helps to sustain the latter's efforts in the long term.

The value of care work has been recognised in South Africa (Cameron et al. 2009) and legislative provision has been made to cater for the registration and training of healthcare providers and staff. However, the literature review suggests that there is a gap in the implementation of the policies with regards to supporting the work of caregivers. Moreover, the bulk of studies done on caregivers come from Europe and North America and it is often the case of informal caregivers that is discussed.

## **Summary**

This study focuses on finding information about the challenges faced by caregivers working with NPOs based in Cape Town; on the support caregivers get from the NPOs and on the support that caregivers need to improve their efficiency and well-being. A human rights approach was used to understand the legal status and rights of caregivers in South Africa and a social exclusion approach has been used to identify the ways in which caregivers lack support. The researcher also used a human needs approach, to point out the fundamental needs of caregivers, and the capabilities approach, to indicate how opportunities for caregivers can allow them to have more life choices. Finally, the people-centred development approach was used to explain

that this research focuses on finding out what types of support caregivers think they need and what caregivers think can be done to make this support available for caregivers. Thus, the next chapter focuses on the methodology used to find out from the caregivers themselves information about the support they that they have and need.

## **CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY**

In the context of this research, semi-structured interviews were done with caregivers and directors of NPOs or child care supervisors to find out about the support given to, and needed by, caregivers working with NPOs in Cape Town. The target group identified was thus caregivers working for NPOs based in Cape Town. The following research design was adopted for this research.

### **3.1. Research design**

This research aims at discovering unknown information that can inform further research since little is known of the realities experienced by the target group (Grinnell, Unrau and Williams 2008). Indeed, so far, the support provided to caregivers working with NPOs in Cape Town has not been explored. This research aims to explore the world of the caregivers working for NPOs based in Cape Town and thus find out about the types of support available to these caregivers. Thus, a qualitative approach was chosen to be able to explore the realities of caregiving work through the caregivers' eyes (D'Cruz and Jones 2004; Engel and Schutt 2010) and determine the issues and challenges faced by caregivers in Cape Town. A qualitative approach enables information to be gathered through the voice of the caregivers themselves through examples of personal views and experiences.

Caregivers and directors of NPOs or child care supervisors were given the opportunity to respond to questions on the types of support that exist within the organisation for caregivers. The study also gave the opportunity for caregivers to state the types of support that they would like to obtain from their organisation, as well as from the State and the non-profit sector. Moreover, this research adds to the knowledge about the challenges faced by caregivers and their expectations regarding the support they need.

Thus, stakeholders of the social services sector in Cape Town can be better informed when formulating best practices and support programmes to assist caregivers.

### **3.2. Gaining entry**

Gaining entry refers to having access to respondents in the context of the research. The term used for the persons who provide the researcher with access to respondents is 'gatekeepers' (Denscombe 2003; Schurink 1998). According to Schurink (1998: 258), "once the researcher has located and established contact with gatekeepers, he or she must gain the person's cooperation". For this study, the different NPOs were contacted via email and phoned to allow the researcher to identify the gatekeepers from the different organisations. The next step was for the researcher to personally visit the NPOs identified to establish contact and gain the trust of the gatekeepers. Data collection in this research involved interviewing caregivers as well as directors of NPOs or the child care supervisors. For this research, in all cases, the gatekeeper was the director of the NPO who provided the researcher access to the caregivers and other staff. The researcher proceeded by explaining the "research procedures and interests to both subjects and gatekeepers" (Schurink 1998: 258) so as to get the agreement of both caregivers and directors and child care supervisors to be part of the research.

### **3.3 Sampling**

Sampling is necessary because it would be very difficult and time consuming to find and study the whole population of caregivers working with NPOs based in Cape Town. To make the research feasible (Strydom and De Vos 1998), the researcher selected a sample from the population of caregivers. A sample is "the element of the population considered for actual inclusion in the study" (Strydom and De Vos 1998: 191). Thus, for this study, the sample was a group of five to six caregivers from each of the four different NPOs, having worked with the NPO for at least two years, and also the caregiver supervisors from the NPOs.

For the selection of the sample, the researcher used purposive sampling as caregivers and caregiver supervisors were chosen by the researcher based on specific criteria of being employed by NPOs for at least two years. This means that the researcher chose the caregivers and caregiver supervisors based "on their unique position" of working with their respective NPO for at least two years (Engel and Schutt 2010: 96). Additionally, it was a non-random sample as each caregiver in the whole population

of caregivers in Cape Town did not have an equal chance of selection (De Vos et al. 1998).

### **3.3.1 Selection criteria**

To select the sample, the researcher needs to know who she or he is looking for as respondents. In this case, the researcher needed to obtain information from the population of caregivers attached to NPOs based in Cape Town. Therefore, the sample of respondents included caregivers, male and female, who have been working in an NPO based in Cape Town for at least two years, and who are receiving a stipend and/ or salary for work done. The sample also included the directors and caregiver supervisors of the NPOs employing the caregivers.

#### **3.3.1.1 The NPOs participating in this study**

- **Home-from-Home**

Home-from-Home (2012) is a registered NPO since 2005 and is based in Wynberg, Cape Town. The organisation provides home community based foster care for children in South Africa. The organisation presently supports twenty-five foster homes scattered over twelve disadvantaged communities of the Western Cape. Home-from-home has the capacity to care for about 160 children and each foster home includes a foster mother (caregiver) and about six children. The children are aged 0 to about 16 years. The children are placed in foster care by court order and are entitled to a child welfare grant. The organisation employs caregivers who work on a shift basis to take care of the children. Some assistant caregivers are also employed to support the foster mothers (caregivers).

Home-from-home focuses on the rehabilitation of the children to family life, social life and into the education system. The organisation works with the community the child comes from to establish a network that can help in the rehabilitation of the child. The organisation also works towards the reunification of the children with their biological families.

- **Beautiful Gate South Africa**

Beautiful Gate South Africa (2012) is a registered NPO and a Christian based organisation located in Cape Town. In 1999, a hospice was opened in East Philippi to care for children dying of HIV/AIDS. The organisation provides care and support to vulnerable children through a community based care facility situated at Lower Crossroads in East Philippi, Cape Town. Children are placed in the care of Beautiful Gate South Africa by order of Court and are thus entitled to the child welfare grant. The organisation has cottages where caregivers are employed to take care of children aged from 0 to about 16 years. Each cottage includes six to ten children. Beautiful Gate South Africa employs 15 caregivers, including 5 day parents, 5 permanent house parents, 4 casual child care workers and one extra permanent care worker. The caregivers work on a on a shift basis and the different caregivers have different functions and roles. Some focus mainly on being a parent to the children, others focus on daily activities with the children, and others have developmental tasks with the children.

The organisation also runs a reunification programme for the children and their families; organises day and afternoon activities for the children; and runs continuous training for its staff.

- **Ons Plek**

Ons Plek (2012) is a registered NPO that works with street children, mostly girls, by providing them a safe place to grow and develop. The organisation provides therapeutic and developmental services that allow the girls to reintegrate the education system and the social system. The organisation opened in 1988 and now administers two residential child and youth care centres, one called Ons Plek, located in the city centre of Cape Town, and another one called Siviwe, located in Woodstock, Cape Town.

Ons Plek employs about 15 caregivers who work on a shift basis to take care of the girls. The organisation also runs a reunification programme for the children to build up the relationship with their families. Ons Plek has programmes to support

academically young people who are in residential care and who live in East Philippi, Cape Town.

- **Marsh Memorial Homes**

Marsh Memorial Homes (2012) is a registered NPO based in Rondebosch, Cape Town. The organisation was originally established in 1901 by Reverend Edward Marsh and the organisation is linked to the Methodist Church. Marsh Memorial Homes provides residential care to children who are survivors of abuse, abandonment and neglect. The children aged from 0 to about 18 years are placed at the organisation by Court order. There are 10 caregivers who take care of about 85 children. There are five cottages at Marsh Memorial Homes and each includes about eight to ten children. There are two caregivers assigned to each cottage, on a shift basis. The caregivers live on the premises of the organisation, in houses attached to the cottages.

Marsh Memorial Homes has youth development programmes for the children, namely in education and life skills, sports, emotional and spiritual support. The organisation also runs a family reunification programme based on the family preservation model the organisation has developed.

### **3.3.2 Sample size**

The researcher interviewed 23 caregivers, including 2 males and 21 female caregivers, and 4 directors and caregiver supervisors from four NPOs for the study. Though the sample size is relatively small proportionally to the total number of caregivers working with NPOs based in Cape Town, the aim of this exploratory study is to generate new ideas and understandings about the challenges faced by caregivers and the support they are getting as well as the support they need. This study does not aim to have a large sample to make findings generalisable (Glaser 1992 in D'Cruz and Jones 2004) but rather aims to add knowledge about support for caregivers and inform further research on the topic.

#### **3.3.2.1 Data saturation**

Data saturation represents a point in the research where even by doing more interviews no new information is found (Suter 2012). This was unexpected by the

researcher but it was truly felt during the last few interviews. However, prior to engaging in the interviews, the researcher had clearly set out a goal of interviewing about 5 to 6 caregivers from each NPO and the caregiver supervisor of each NPO. This goal was attained although the researcher excluded 2 interviews from the end total as it was deemed unnecessary to include them, both of them included caregivers who had worked less than 2 years full time with the NPO and they did not add on any new information for the research.

### **3.3.3 Sampling type**

Since the researcher already had a specific group of people she wanted to interview, the sampling type is purposive. The sample of caregivers was chosen by the researcher “with a specific purpose in mind” (Denscombe 2003: 15). Purposive sampling is when the selection of respondents is “based entirely on the judgement of the researcher” (Strydom and De Vos 1998: 198). This implies a non-random, non-probability, sample where each individual in the population of caregivers, working with NPOs based in Cape Town, does not have an equal chance of being selected (Strydom and De Vos 1998). The researcher chose participants based “on their unique position” (Engel and Schutt 2010: 96) of being caregivers for at least two years and working with NPOs based in Cape Town for a stipend or salary. This means that participants were chosen based on whether they fit the selection criteria of the research.

## **3.4 Data collection methods**

### **3.4.1 Semi-structured interviews**

Semi-structured interviews were done in a face-to-face, one-to-one, manner between the researcher and the respondents. The researcher used semi-structured interviews to enter into a conversation with the caregivers and NPO directors and caregiver supervisors so as to result in a “joint construction of meaning” (Janesick 2004: 72) about the types of support provided to the caregivers by the organisation they are attached to. Semi-structured interviews allowed the researcher to have “a clear list of issues to be addressed and questions to be answered” through the use of an interview schedule (Denscombe 2003: 167). Semi-structured interviews enabled a “relatively



systematic collection of data and at the same time ensure that important data are not forgotten” (Schurink 1998: 300). Additionally, it was possible for the researcher to be flexible about the order in which the questions from the interview schedule were asked and this allowed the respondent to speak more lengthily about certain issues (Denscombe 2003).

Semi-structured interviews were done at the NPOs where the caregivers and caregiver supervisors worked during the months from June to October 2012. The interviews lasted from 40 minutes to 65 minutes each.

Once the respondents had agreed to do the interview, and before actually starting off with questions, the researcher restated the purpose of the study as being to find out more about the support available to caregivers working with NPOs based in Cape Town and the additional support that caregivers need.

The researcher explained ethical issues of confidentiality and anonymity to the respondent and it was made clear to respondents that the research may not necessarily bring about any change in their work conditions and work environment. The respondents were also told that they can stop the interview whenever they want and that they are not forced to answer any questions. It was also indicated to respondents that there are no ‘right’ or ‘wrong’ answers to questions, but to simply give their opinion about what would be asked.

Then, the researcher confirmed voluntary participation of the respondents in the research and asked for the verbal consent of the respondents to record the interviews using a voice recorder and to use the interview schedule and a note book during the interviews. Respondents were given the option to use a pseudonym or nickname during the interview.

The interview started with questions relating to the profile of the respondents, namely biographical details such as age, number of years as a caregiver, marital status, and place of stay. Then, the researcher went through other sections of the interview schedule to answer the main research questions. The order of questions varied from respondent to respondent.

Once the researcher had completed the interview, and the voice recorder was turned off, the respondents were debriefed. They were thanked warmly for their time and participation and asked how the whole interview process has been for them. Respondents were thanked again before parting from the interview venue.

### **3.4.2 Data collection instrument**

An interview schedule was used as a guideline during the interview process. The interview schedule includes mostly open-ended questions related to the main research questions. (Please find the interview schedule attached as Appendix A).

The main research questions revolved around the work of caregivers and their challenges, the types of support caregivers obtain from NPOs, the impact of the support given on their work, and the support needed by caregivers. However, it is to be noted that the interview schedule was used rigidly by the researcher during the interviews.

### **3.4.3 Data collection aid**

The interviews were recorded using a digital voice recorder. The researcher obtained the consent of respondents to use the device before the interview. The researcher also had a notebook at hand in case any note taking was necessary during the interview.

## **3.5 Data Analysis**

After completing interviews, the researcher transcribed them manually and printed out the interview transcripts for analysis. After all the interviews were transcribed, the researcher analysed them using Tesch's (1990 in De Vos, Strydom, Fouché and Delpont 2002) approach. This approach puts forward the following eight steps for analysis:

1. The researcher gets a sense of the whole data collected by reading carefully through all the transcriptions, and jots down some ideas as they come to mind.
2. The researcher selects any one transcript and goes through it asking "What is this about?" and thinking about the underlying meaning in the information. The researcher writes thoughts coming to mind in the margin.

3. When the researcher has completed this task for several transcripts, a list of all the topics is made, and similar topics are clustered and formed into columns that can be arranged into major topics, unique topics, and leftovers.
4. The researcher takes the list and returns to the data. The topics are abbreviated as codes and the codes written next to the appropriate segments of the text. The researcher tries out this preliminary organising scheme to see whether new categories and codes emerge.
5. The researcher finds the most descriptive wording for the topics and turns them into categories. The total list of categories is reduced by grouping related topics. Lines are drawn between the categories to show interrelationships.
6. A final decision on the abbreviation for each category is made and the codes are alphabetised.
7. The data material belonging to each category is assembled in one place and a preliminary analysis performed.
8. The researcher recodes existing data if necessary.

### **3.6 Data verification**

Data verification is about the internal validity of the information collected (Poggenpoel 1998). This means that the researcher is to check for any biases that can contaminate the process of data analysis and discussion of findings (Poggenpoel 1998). According to Guba and Lincoln (1982 in D'Cruz and Jones 2004), in qualitative analysis, this involves addressing the issue of 'trustworthiness' to test the rigour of findings. Guba and Lincoln (1982) state that following four conditions for a research to be trustworthy:

- the truth value of the findings, implying validity of results;
- the applicability to other contexts. That is, whether the research findings can be applied to and used for other contexts; and
- the consistency of the findings assuming similar respondents and contexts. This last point refers to the reliability of the research. That is, the ability to replicate the research in a similar context and under similar conditions and obtaining the same results (Haralambos and Holborn 2008); and
- the neutrality as far as representing the views of respondents is concerned.

The above-mentioned issues were considered for this research and limitations arising were included in the research report.

### **3.7 Limitations of the study**

During the whole research process, the researcher encountered issues that may have impacted on the information collected and on the analysis and formulation of results and recommendations. Such shortcomings arose from unpredictable events as well as from the research practices adopted by the researcher. The researcher provides information on how such shortcomings were dealt during the research.

#### **3.7.1 Subjectivity of the information collected**

As indicated by Seedat, Duncan and Lazarus (2001), the answers and comments of respondents during interviews may only reflect the personal experiences of the latter and may not represent the objective truth. Moreover, the answers of respondents may have been influenced by various external factors that cannot be controlled by the researcher in the context of semi-structured interviews. However, the purpose of this research was to get a picture of how the caregivers and their supervisors view the support given and needed by caregivers. The statements of both the caregivers and their supervisors were taken into account to have a balanced picture of the issues raised.

#### **3.7.2 Lack of generalisability of findings**

Using the non-probability sampling type, namely purposive sampling, does not guarantee that the sample of respondents participating in the research are representative of the whole population of caregivers employed by NPOs in Cape Town. Moreover, the sample of respondents for this research is small. Therefore, the research findings are not applicable to a wider population of caregivers attached to NPOs based in Cape Town because the caregivers and caregiver supervisors participating in the research cannot be considered as a homogeneous group (Heath et al. 2009; Seedat et al. 2001). However, this research aims to add to information available about caregiver support by NPOs based in Cape Town and to inform further research rather than to use findings for generalisation.

### **3.7.3 Relativity of findings**

The findings of a research may depend on the interpretations made by the researcher when analysing the information collected from interviews (Seedat et al. 2009). This is because the researcher might use value judgements when analysing the information. In this research, the researcher tried to avoid this, as far as possible, by probing for clarifications during the interviews (Heath et al. 2009) and through reflexivity throughout the research process (D'Cruz and Jones 2004; Finley 2003).

Additionally, the researcher analysed the interview transcripts alone and therefore, the risk remains that the main themes and objectives extracted are not objective but influenced by the researcher's prior knowledge of the research topic. The researcher tried to remain objective and re-did the analysis three times to confirm the main themes and categories extracted.

### **3.7.4 Over-emphasis on the interpretation and understanding of the respondent's personal experiences**

This refers to the researcher probing too much and getting too much detail about the experiences shared by the respondents. The data collection process is then similar to individual case studies of respondents rather than getting the opinions of caregivers and caregiver supervisors on to the support given and needed by caregivers. The researcher moderated the responses of respondents during the interviews. This prevented respondents from giving too much detail about their role but rather allows them to focus on external factors and constraints that might be impacting on them and their work (Heath et al. 2009).

### **3.7.5 Limitations of semi-structured interviews**

Semi-structured interviews might lead to researcher bias and interviewee bias, as well as having the identity and presence of the researcher influencing the responses of the young people during the interviews (Haralambos and Holborn 2008). However, the researcher tried, as far as possible to limit these by following ethical research procedures and adopting an appropriate behaviour during the interviews.

## **Summary**

After completing the data collection process, the interviews were transcribed manually. The interview transcripts were then analysed. First, the demographic profile of the caregivers and caregiver supervisors was analysed. This information is presented in the next chapter in Table 1 and Table 2.

Then, using Tesch's approach, the main themes and sub categories were extracted from the interview transcripts. The main themes and categories are shown below in Table 3. The main themes link directly to the main objectives of the research. The categories attached to the main themes are used in a discussion process to present and understand the information collected during the interviews.

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## **CHAPETR 4: FINDINGS AND DISCUSSION**

The findings and discussion provided in this chapter result from the analysis of the interviews done by the researcher with caregivers and their supervisors from the four afore named NPOs.

### **4.1 Profile of respondents**

The tables below provide a brief profile of the caregivers and caregiver supervisors who were interviewed for this research.

#### **4.1.1 Profile of caregivers**

5 to 6 caregivers were interviewed per NPO, giving a total of 23 caregivers interviewed in all. This total included 21 female caregivers and 2 male caregivers. These figures reflect the data gathered during the Thogomelo project whereby most caregivers were women (Department of Social Development 2011). This indicates the high presence of women in the field of caregiving in South Africa, especially with children.

Table 1 below provides details on the profile of caregivers interviewed for this research.

**Table 1: Profile of caregivers**

<b>Name</b>	<b>Gender</b>	<b>Age</b>	<b>Marital status</b>	<b>Number of own children</b>	<b>Level of Education</b>	<b>Previous experience in caregiving</b>	<b>Years with NPO</b>
Trisha	Female	37	Single	1 (adult)	Grade 12	Preschool carer	7
Florence	Female	43	Married	2 (Adolescents)	Grade 11 and first aid and child minder short courses	None	6
Saps	Male	36	Married	0	Grade 11	None	12
Zola	Female	47	Single	2 (Adults)	Grade 11	None	3

					and Nursing school		
Besh	Female	29	Single	2 (Adolescents)	Post Grade 12: Short courses in childhood, HIV and counselling	Volunteer community work	3
Anna	Female	40	Married	3 (1 Young child and adolescents)	Grade 12	Volunteer community work	9½
Nicki	Female	44	Single	2 (Adolescent)	Post Grade 12: Diploma in commerce	Private child caregiver	7
Dorothy	Female	56	Single	1 (Adult)	Grade 9 and Caregiver short course	Caregiver	4
Mary Jane	Female	63	Married	3 (1 Baby and 2 young children)	Grade 10	Housemother, caregiver	7
Vundo	Female	48	Single	1 (Adult)	Grade 11 and Diploma in hotel training	Childcare worker	3
Marise	Female	54	Divorced	2 (Adults)	Grade 9	Au pair work	3
Pricilla	Female	43	Divorced	3 (2 Adolescents and 1 Adult)	Grade 10	Crèche experience	4
Ali	Male	44	Married	3 (1 toddler, 1 young child, 1 adolescents)	Grade 12	Childcare worker	4½



Carmen	Female	37	Engaged	1 (1 toddler)	Post Grade 12: Social Auxiliary course	Childcare worker	5
Matty	Female	46	Married	2 (Adolescents)	Post Grade 12: Preschool training and basic psychology in college	Worked in crèche, preschool & did community work	7
Mpha	Female	37	Single	1 (Adolescent)	Post Grade 12: College	Child care worker	5½
Petro	Female	56	Widowed	2 (Adults)	Post Grade 12: receptionist course	Caregiver	5
Amy	Female	37	Divorced	0	Grade 12	Caregiver, volunteer community work, project coordinator	11
Jenny	Female	43	Married	2 (Adolescents)	Grade 12	Caregiver	3½
Wewe	Female	40	Married	3 (2 Adolescents and 1 adult)	Post Grade 12: Home Based Care short course	Child minder	4
Ntabiseng	Female	43	Single	2 (1 adolescent and 1 adult)	Post Grade 12: Home Based Care short course	Domestic work including caring for an infant	5
Nox	Female	34	Single	1	Post Grade	None	4½

				(Adolescent)	12: Degree in Education, 3rd year in college		
Zenda	Female	44	Single	3 (1 young child and 2 adolescents)	Grade 11	Caregiver	4

The average age of caregivers interviewed was 43½ years. The youngest caregiver interviewed was 29 years and the oldest was 56 years. The fact that this research deals with caregivers who are formally employed by NPOs, the age range does not go beyond the usual retirement age in South Africa, namely 60 years.

10 caregivers reported being single, 8 were married, 3 divorced, 1 engaged and 1 a widow. 2 out of the 23 caregivers participating in the research reported not having children of their own. Most reported having between 1 child to 3 children. 15 of the 23 caregivers had children under 18 and who they were still supporting economically.

The caregivers interviewed had worked between 3 to 12 years with their respective NPOs. On average a caregiver has been employed for 5½ years with the same NPO. All caregivers interviewed had educational qualifications. The lowest educational qualification reported by a caregiver was Grade 9. There were 5 caregivers who had had only a Grade 12 certificate while 9 caregivers stated having post-Grade 12 qualifications which included short courses in home based care, caregiver courses, commerce and receptionist. The others had high school qualifications below Grade 12 but above Grade 8 and had done courses in fields such as nursing, child minding and hotel training.

The analysis of the interviews revealed that all caregivers who did not live on site use public transport to get to their place of work. It was also noted that none of the NPOs covered the transport costs or travelling costs of the caregiver from and to their place of work.

#### 4.1.2 Profile of caregiver supervisors

One caregiver supervisor was interviewed per organisation, providing a total of 4 caregiver supervisors interviewed in all. The caregiver supervisors were either the director of the NPO or the manager of the caregivers. All the caregiver supervisors interviewed were female.

Table 2 below provides details on the caregiver supervisors interviewed for the research.

**Table 2: Profile of caregiver supervisors**

<b>Name</b>	<b>Gender</b>	<b>Number of years as caregiver supervisor</b>	<b>Previous experience</b>
Jane	Female	7	About 30 years in social work
Ginger	Female	4	Community development with focus on empowerment of street people
Veronica	Female	2	Child care work
Pam	Female	24	Social work and child welfare work

#### 4.2 Framework of themes and categories

The following framework, shown as Table 3 below, provides groupings of findings under specific themes and categories related to the objectives of this research. The findings were grouped based on a common category and the categories were linked to themes using Tesch's (1990 in De Vos, Strydom, Fouché and Delpont 2002) approach.

**Table 3 Tabular representation of themes and categories**

<b>Themes</b>	<b>Categories</b>
4.2.1 The typical caregiver	4.2.1.1 Activities in the workplace
	4.2.1.2 Personal interest in children and caregiving
	4.2.1.3 Status of caregivers
4.2.2 Support available for caregivers	4.2.2.1 Social support
	4.2.2.2 Capacity building of caregivers
	4.2.2.3 Financial rewards
	4.2.2.4 Time off and recreational activities
	4.2.2.5 Transport facilities at workplace
	4.2.2.6 Access to facilities and services of organisation
	4.2.2.7 Counselling services for caregivers
4.2.3 Impact of existing support on caregivers	4.2.3.1 Type of commitment to the NPO and relationship with management
	4.2.3.2 Personal satisfaction
4.2.4 Challenges experienced by caregivers	4.2.4.1 Challenges faced with children
	4.2.4.2 Challenges faced with NPO
	4.2.4.3 Work-family life balance
	4.2.4.4 Financial issues
	4.2.4.5 Physical safety issues

	4.2.4.6 Rights of caregivers
4.2.5 Type of support needed by caregivers from their respective NPOs	4.2.5.1 NPOs to work with government and private sector
	4.2.5.2 Significant increase in salary
	4.2.5.3 Acknowledgement of work done by caregivers
	4.2.5.4 Access to information regarding policies related to caregivers
	4.2.5.5 Provision for physical and moral well-being of caregivers
	4.2.5.6 Additional staff
	4.2.5.7 Transport facilities
	4.2.5.8 Communication with the management and the board of the NPO
4.2.6 Support needed from civil society	4.2.6.1 Role of the NACCW
4.2.7 Support needed from government	4.2.7.1 Policies related to the work conditions of caregivers
	4.2.7.2 Increase capacity building opportunities for caregivers

Throughout the presentation of findings and discussion, statements provided by caregivers and caregiver supervisors during interviews are quoted to reflect the realities experienced by caregivers.

#### **4.2.1 The typical caregiver**

The research provided the opportunity to gain more insight on the caregivers employed by NPOs based in Cape Town. The findings reflect the activities involved in the work of the caregivers, their personal interest in care work and the status of caregivers.

#### 4.2.1.1 Activities in the workplace

The caregivers described their activities at work. These involve tasks such as waking up the children in the morning and helping them to get ready for school, preparing food, cleaning, supervising the cleanliness of the children's living space, checking their homework, doing administrative tasks and administer medication.

The tasks of caregivers vary based on the age and medical condition of the children they take care of and on the living arrangements made with the NPO. That is, whether caregivers stay on site or come for day or night shifts.

*"...I wake up 4.45 a.m. I have to put the water in the bath for the children and then I wake them... I'm busy making pap and the lunches... I'm busy with the youngest ones to dress and to do all those things...after that I serve the pap before they finish to bath before they wear their clothes... The time they are finished I have to wash their dishes, I have them wearing their clothes and then their transport taking them and the others are going to school. Then I...clean their rooms and everything. Prepare lunch for them when they come back from school, and then after that I cook supper."*  
(Vundo)

*"...On Sunday I will order groceries and stuff... fill out a slip because there is times where they [the children] don't go home or when things change...There is need to ask money for the child then, weekly monthly groceries, request for travelling money on a weekly basis... What needs to be report on a weekly basis. During the week from then onwards you find time to do admin..."* (Ali)

*"...first check the medication...if it is correct and you sign down on the notice board for every medication. If the medication is short you go back, you phone the nurse, and they fix the medication... Then go back to the cottage. You see the boys coming in from school. They must wash their shirt, clean their shoes, check if their rooms are ugly... After you just have a moment to sit down, ask them if anyone has homework, and see if it is difficult, I call my partners to help with the homework... Then, after 4.30 p.m. fetch the lunch, supper or dinner. You prepare the dinner for them for the evening... After dinner, cleaning for the whole place...we do a handing over. So if*

*there is any accident I report...I have a notebook. Like a daily report, every time you come you sign and date.” (Saps)*

The responsibilities of caregivers vary based on the NPO they work with as facilities are not equally provided in all NPOs. For instance, Saps indicated that partly cooked meals are provided by the NPO while Vundo had to cook all meals.

The activities of caregivers reflect the activities of daily living mentioned by Prachakul and Grant (2003). However, contrary to Zarit’s (2009) affirmation, the caregivers in this research are not family members of the children in care, and they do not share the sole responsibility of the children.

#### **4.2.1.2 Personal interest in children and caregiving**

The caregivers interviewed expressed genuine care and interest in the well-being of the children.

*“I have a passion for this job. I like to work with children and especially to care for them...” (Jenny)*

*“...the children make me happy everyday because am happy when I see them, because laugh and I like them...” (Nicki)*

*“...It’s nice to be here to be with the children. I like to be with the children.” (Nox)*

*“When I come to work, first of all I come to help the children. That they are growing in a right way. To encourage while this place is taking children who are HIV positive and children who have got no mother and father. So I just come to encourage them... to empowering them and caring...” (Zola)*

*“...I have stayed with them [the children] for a long time, the other one been 7 years or 8 years. It’s been a long time, others even take me as their mother, they are used to staying with me, so I just can’t break off they are like my children.” (Nicki)*

Guberman (2010) stated that the type of relationship between the caregiver and the person in care, in this case, children, is determinant in the quality of care provided.

The caregiver-child bond was evident in cases where the caregivers lived on site with the children as opposed to working on shifts.

*“...these are not my children but on the very first time whenever they accept me as their mother...it’s good because we do everything together, they listen to me and they feel now now mama. Even though they’ve got activities at school, if I’m not there they are not feeling good. They always tell me or they ask someone, the caretaker whatsoever must come and fetch mama so that mama must see and they brag, like to other children, look at my mother! I’m proud of that because I do good with them.”*  
(Vundo)

As highlighted by Guberman (2010) there are various dimensions of the work of a caregiver. Similarly, caregivers stated that working with children involved more than doing basic caring tasks.

*“... Not every day is the same. You face new things everyday whereas carer you are just stuck there. It’s just caring, home-caring but here you have to deal with other issues, solving problems, caring for the children in different dimensions, emotionally and physically. That is why I enjoy.”* (Jenny)

*“...like every child is a different challenge because each child got a different background and they got different mindsets ideas... So it is challenging and for me at this moment I can say maybe I still need that challenge in life at this particular moment. You always have something new to deal with.”* (Marise)

Many caregivers stated having chosen this path because of a personal interest in taking care of others, especially children.

*“Ever since I was young I always loved kids. When I was 10 years old and I was looking after my sister’s baby. I did Sunday school teacher. I used to do holiday clubs. Run volleyball camps with under-privileged kids.”* (Amy)

*“I was a child, I like to take care of people. I used to say I want to be a nurse or a doctor and when I grew up. In my family most of my siblings used to get sick and there was no one to take care of them sometimes there is no food inside the house,*



*sometime you see there is an elder who is sick so the children are the ones taking care of them...I choose when I grow up, I really wanna help people...*” (Anna)

*“...when I was a child I was actually stealing food at home because I wanted to share with my friends at school because now I know there was other kids if they are not my friends if they are hanging around because they don’t have food because I give them my food... then I realized I can become a child care worker or a social worker to help other people and especially the kids my heart was with the children.”* (Mpha)

The fact that most caregivers reported having freely chosen their career paths can be linked to Sen’s (1999) freedoms approach to human development, which advocates for people choosing the lives that they want through access to freedoms.

#### **4.2.1.3 Status of caregivers**

The status of caregivers is often defined by the conditions and regulations under which they are employed. In South Africa, the National Association of Child Care Worker (NACCW) has set up a board to deal with registration issues of child care workers.

*“...when you finish all your module of NACCW, then you are a qualified child care worker. But even if you got experience you will still be acknowledged as qualified, like more than four or five years. You get registered with the NACCW but only if you finish your 14 modules. You can register yourself as a member of the NACCW before though.”* (Jenny).

However, according to some NPOs, not all caregivers working with children qualify as child care workers. For instance, some NPOs employ foster mothers who are employed under conditions different from child care workers, namely that of living full time with the children.

*“...the child care workers are considered people who work on child care centres and youth care facilities and they are generally a bit more trained. It’s a different role altogether...I think the perception is if you are a child care worker you might have more qualifications, training experience and our foster mothers are more the mothers of the children on a daily basis... They want to be mothers in their own right, in their*

*own home and they have a lot more, quite a few more benefits because of that, living in their own home and the perks you get with that...” (Jane)*

The Children’s Act (No. 38 of 2005) states that child care workers and foster mothers are caregivers. Thus, it would be up to the NACCW to apply this legislation in case foster mothers wish to get registered with them. Another option for caregivers in general, including foster parents, would be to set up a professional board to represent caregivers throughout South Africa, as per the Advisory Board on Social Development Act (No. 3 of 2001).

Nevertheless, caregivers are employed based on specific criteria that also define the status of their job.

*“...we want somebody to be 40 plus and who does not have dependent children of their own. Couples are best, number one is a couple. To like children, to love children, to be committed, to have some work ethics and some work record but it’s really about caring for children above anything else.” (Jane)*

*“... it’s based on their attitudes towards children whether they are judgemental or not. Their ability to change and grow... There’s got to be some ability to do petty cash. There’s got to be an ability to write in English because all the things are written in English. The growth is the most important part. People must have a matric at least and they must be interested in progressing further with the NACCW.” (Pam)*

The average age of caregivers included in the research study was above 40 years and all caregivers expressed a liking for children and child care during their interview.

The findings of this research indicate that caregivers employed by NPOs fit a certain profile that indicates their position in society. This profile is that of someone who:

- has at least attained the secondary level of education;
- some knowledge and experience of issues in care work;
- can manage with reading, writing and speaking English;
- has a caring and responsible attitude;
- is a low-income earner;
- can count and has the ability to learn further;

- is usually aged around 30 years or beyond, but is below retirement age; and
- is usually female.

This profile is somewhat close to the one depicted in the Thogomelo project (Department of Social Development 2011) of the middle-aged female with low education and low income.

#### **4.2.2 Support available for caregivers**

Findings regarding the type of support available for caregivers in the NPO they work with included having other NPO staff to support the work done with the children, namely social workers, a nurse, a child psychologist, the director and a supervisor. Other types of support given by the NPOs were access to training and capacity building, a salary, recreational activities from time to time, transport facilities and access to other services offered by the organisation.

##### **4.2.2.1 Social support**

The NPOs provide social support in the form of support staff who work with caregivers to ensure that the children get the best care. All the NPOs included in the study had at least one social worker, caregiver supervisors and a director. Other support staff for caregivers included a nurse on site or on call, a doctor on call, a play therapist, a music therapist, an occupational therapist, assistants or replacement staff, family reunification officers, counsellors, volunteers and kitchen staff.

*“If I’m really in a struggle I will talk to my senior child care worker or the social worker. I always feel free to go to even our boss I will go to him as well. I have a good relationship with everyone so.” (Petro)*

*“...they [the organisation] support me, we work as in a team. So I can sit down, even meet like Thursday I have cottage meeting. We talk about the challenge in the cottage meeting...” (Saps)*

*“...what I like, once a month we got all our organisation’s mothers we gather together as mothers it’s something like that we share things like different opinions. You pick upon the nice things with the others.” (Mary Jane)*

*“...if you would get sick they [all staff] would all come and visit you, which isn’t always what you want. But everyone cares, like, everyone would come by, you know you aren’t feeling well you don’t want people around you, like me, but they will go the extra mile and come over and bring flowers which I don’t even like. Also, the other good thing is like the supervisor is like a big sister she’s work and personal and know that she is going to give me the big sister advice, support.” (Carmen)*

*“...sometimes if I haven’t got other stuff, I phone [management] for like electricity, food...each and every time, if I’ve got a problem like the two boys who are 13 and 12. Sometimes they are not doing fine at school, corrupt, doing stuff, bad stuff. They [management] are always there for me when I phone them... I do always phone and they are coming.” (Vundo)*

Many caregivers had positive reactions to the support they get from co-workers, management and other staff members. This is in line with findings by Drentea et al. (2006), Spiegel and Kimerling (2001), Riggs and Rantz (2001) and Roth et al. (2005) who found that social support contributed positively to the life of caregivers in many aspects.

The Ubuntu principle, as described in the White Paper on Social Welfare (Republic of South Africa 1997), is also reflected in many of the statements of caregivers who acknowledge the support of others and who provide support to others in their organisation.

*“...we [the whole NPO staff] used to do a staff breakfast for Christmas... Last year there was a whole discussion, can we do it? We may not get even bonuses this year. Everybody said we’ll buy eh, I think Spur or somebody sponsored us a cup of coffee. Everybody said okay that’s what we are doing. So it’s like a joint decision which I think is amazing. And they chose the very small option...” (Pam)*

However, support staff are sometimes seen by caregivers as lacking efficiency and seriousness in their work.

*“We’ve got a problem with the assistants. They [management] think they help us but they don’t...my children they are complaining, no mommy we didn’t eat the meat the*

*time you were not here...They [the assistants] take our children's clothes...sometimes you don't feel like taking an off because you know...I don't trust them..." (Dorothy)*

*"They [the previous assistants] don't have the patience or they don't have the compassion...I had like maybe four and you know it didn't work out... It was chaotic, they don't wash my kids, they don't feed them properly...they just don't care! That is the thing that I, I'd rather stay here, not take a weekend, not take leave and stay and see that these kids are looked after properly, fed properly." (Marise)*

*"...I think the family preservation doesn't know nothing of the child ...the family when they phone they don't phone to the family place they want to speak to the child care worker... it's a waste of money... It's also difficult with the social worker. You must work but you must also fight...because our social worker doesn't do what she is supposed to do at all so but you must push fight until she do it." (Mpha)*

The above issues with support staff was reported only by some of the caregivers. These issues indicate that either the support staff is not adequately trained or that there is a lack of knowledge regarding the tasks and responsibilities of each and everyone at different levels. Indeed, caregivers may not be fully aware of the role of assistants, the social worker and the family reunification officers and as such have unrealistic expectations about what the support staff should be doing. There might also be inadequate communication from management on the contribution of support staff to the work of caregivers.

#### **4.2.2.2 Capacity building of caregivers**

All caregivers referred to receiving some training when they first joined the organisation. This practice by NPOs is in line with findings by Navaie-Waliser et al. (2002) who found that caregiving is a work that demands preparation and support.

*"First when I came here, I didn't have the experience on what I was gonna do. So they train me here. Someone, an old ccw will have to train you. So I was lucky I was a fast learner. I think I was trained just for nine days. Then, I was put on my shift to work alone." (Wewe)*

*“I like the training they give us. They make us grow and they make us know more about the children. Even if you are outside if I find a child crying I just can’t go pass, I have to ask why the child is crying.” (Florence)*

*“When I came I didn’t have experience, I didn’t know nothing about this job, but as the moment I work here, I can say that I have more responsibility, I learned to be human so that you can take care of the other people, of the other children’s people you see. So you can be socialised.” (Nox)*

Moreover, the NPOs included in this research study facilitate further training for their caregivers through the NACCW and they also have other resource persons coming in from time to time for different types of training sessions with their caregivers. Caregivers are given time-off work to study and to attend workshops. However, issues arise as not all caregivers can take time-off for workshops at the same time.

*“...[the NPO] give us some training at the NACCW. NACCW is about how to, we’ve got different modules, from module 1 until module 14. This is whereby they help you how to work with children who got behaviours. Because these are the children that I work with at [the NPO].” (Wewe)*

*“...if you look at some [caregivers] they are doing their own courses. We [the NPO] normally allow them time to do that, for education. To grow themselves. It is quite a support because we allow support for them to go on leave to do that like the ECD...” (Ginger)*

Burchinal et al. (2002) indicated that additional training and capacity building is indeed beneficial to caregivers in the sense that this training enables caregivers to provide quality care to the children. With regards to further training for caregivers in South Africa, apart from what is provided by NACCW, the Department of Social Development (2011) has invested in the training of community caregivers working with the government through the Thogomelo project. Such training could also be beneficial to caregivers working with NPOs.

#### 4.2.2.3 Financial rewards

All caregivers interviewed stated they received a monthly salary from the NPO. The amount varied broadly from R2000 to about R6000. For some caregivers, the salary would increase annually while for others the increase was dependent on their performance as caregiver in the NPO.

*“... it’s [the salary] about R5600. I’m a senior Child Care Worker so I think I am paid a little more than the others because I have more responsibilities.” (Amy)*

*“It [the salary] has increased yes yearly because they [the NPO] increase it according to your performance. Because every April we do have eh...you talk with your supervisor how far you are, how far you have grown you see. Stuff like that. And then they have this good fair and something. So according to the rate they give you a salary increase...” (Ntabiseng)*

The NPOs find it difficult to support their caregivers financially as their budget is often very tight and dependent on donors. However, when possible, the NPOs provide salary increases and bonuses.

*“Recently we [the NPO] were able to give them [caregivers] a cash bonus, some volunteers had given us some money, we gave them that...” (Jane)*

Indeed, caregivers indicate that their basic salary is not enough to reward the load of work they handle.

*“... The salary is lower than the job we are doing. The job we are doing is tough and it’s 24/7. It’s challenging really. We have to be here, there for these children 24/7. You do everything, you’re really a mother of the child and the salary is not good enough.” (Vundo)*

There is no indication in the literature review that the Department of Social Development or the South African government have regulations regarding salaries for caregivers in South Africa. Moreover, since caregivers in this research study are employed by NPOs, it is likely that their salary is restrained by the budget of the NPO.

#### 4.2.2.4 Time off and recreational activities

The caregivers reported that the NPOs provided recreational activities such as outings, retreats, and gatherings, either on a yearly basis or twice per year. Other small treats for caregivers happened on special occasions like their birthdays and Mother's day.

*"We [caregivers] go for retreats, they [management] organise..." (Jenny)*

*"They [the NPO] support us because they take us out in December, they make a Christmas party for us. On Mother's day they give us presents, on my birthday they buy me a card talking nice things about me and chocolate. At least these small things help them make me feel like part of the family because they know my birthday...."*  
(Florence)

*"The organisation they support us [caregivers] very well. They give training, they give for the outside like maybe we go outside coming together sharing food. Programme holiday for the year... Sometimes they celebrate Father's day, Mothers' day..." (Saps)*

Some caregivers also indicated the importance of having some time on their own during the week to do what they like. Some, on the other hand, did not take time off from the children, although the organisation makes provision for them to do so.

*"To just relax sometimes, close the door maybe you read your Bible and other things." (Vundo)*

*"...you must not let push you all the time, you must tell yourself you working here but you must also take your time and relax do your own things in a way..." (Pricilla)*

*"...one of our foster mothers...won't take time off. She needs to take it but doesn't want to and it is difficult actually physically forcing her off, but I think we [the management team of the NPO] are going to have to so that we give them the opportunity to have a long weekend off." (Jane)*

Indeed, findings that some caregivers and their NPO do find it important to have time off work is supported by studies done by Liu and Gallagher-Thompson (2009), Lynch



et al. (2009) and Ho et al. (2005). Their findings indicated that caregivers may experience adverse psychological issues such as depression if they do not take sufficient time off from work to do what they want and spend time with their close ones.

Nevertheless, some caregivers expressed dissatisfaction that their holiday leave was cut abruptly, without consultation.

*“...our offs are little...like one weekend a month and they did not think because especially for the people who do not know the work, but we can't do otherwise... But that is not the way you just cut the leave like that the whole way...they change without asking...sometimes they are things that you want to make right at home and with just two weeks off you are still tired you see. Because you have got your own house to run...”* (Mary Jane)

According to the Basic Conditions of Employment Act No. 75 of 1997, although caregivers are entitled to 21 consecutive days of annual leave, where the caregiver takes single days off, the number of off days is reduced. Nevertheless, the work of caregivers involves a lot of time spent at the workplace, especially for night shifts. The fact that the time off of caregivers is thus less than for other jobs implies that caregivers have less time to have a social life beyond their workplace. With reference to Max Neef (1991), this might mean that caregivers are not given the opportunity to fulfil the fundamental human needs of leisure and freedom. As indicated by O'Brien (2009), this might result in caregivers turning to pseudo- or inhibiting satisfiers that may only meet their needs momentarily and limit their well-being.

#### **4.2.2.5 Transport facilities at workplace**

Some of the NPOs provide transport facilities, such as cars and a driver to take children to school and for hospital visits. This makes it easier and less time consuming for the caregivers who need to accompany the children.

*“There is transport every morning and afternoon. They [drivers] take them (the children) and bring them back. The drivers. When it is a medical report, I'm the one*

*like I'm the driver for the hospital, the clinic, or the psychologist or wherever. If there is a school activity after school hours, I will go fetch the children ya."* (Petro)

Additionally, one of the NPOs provides monetary incentive for caregivers who do not have a drivers licence, to learn how to drive.

*"Ya they [the NPO] organise everything like for learners and for licence but this year they organise the driver's course and then you pay for yourself from your own pocket. When you have the learners, they give the amount of the R1000 for the driving..."* (Saps)

By providing incentives, such as transport facilities, for caregivers to become more independent in their work, the NPO builds up the skills of its employees and increases their effectiveness. Additionally, there is then no need for the NPO to employ a driver for the transport of the children and the caregivers.

#### **4.2.2.6 Access to facilities and services of organisation**

Both caregivers and their supervisors stated that allowing caregivers and their families to use some of the services provided by the organisation was an important form of support. This favoured a sense of belongingness of caregivers to the organisation.

*"... Staff can bring their children with over weekends but as long as they do their job first to see the work is done and the organisation does not have a problem."* (Jenny)

*"... [the caregiver] was having trouble with her son's schoolwork. So I [caregiver supervisor] offered our homework sessions. So they [caregivers] are free to use the services of the organisation as long as it does not interfere with the dynamics of their work with the children..."* (Pam)

Because of the nature of caregiving work with children, and the fact that there are always unforeseen events whereby caregivers need to adapt their hours to the situation at hand, it is important that caregivers feel cared for by the organisation. This refers to the Ubuntu principle (White Paper on Social Welfare, Republic of South Africa, 1997) whereby caregivers and the management staff of NPOs show feelings of mutual care by sharing resources and support.

#### 4.2.2.7 Counselling services for caregivers

Some NPOs were able to provide counselling as support to caregivers on an occasional basis.

*“... And then if you got a problem, personal problems they [the NPO] arrange for you a counsellor, which I find very good. When the need is there, the organisation arranges the person and they pay.” (Jenny)*

*“Last year, we did, two staff were paid for to either have massage or counselling by a social worker...Some people [caregivers] don’t get the option. Some people I [caregiver supervisor] say you must have counselling because of their difficult circumstances. But some people just chose the social worker and others just chose the massage. So it just depends, if there is a need and a resource available.” (Pam)*

*“...One [social worker] used to have time on a one-to-one with them. So the new one is also trying to have like individual session with them. But now it’s too much work because she is only one left. So basically we are going to advertise... To have someone with whom they can actually share out. But the organisation it depends on whether people utilise them or not. We actually have care and development staff, HR and two that are doing pastoral care... It includes that [counselling]. If there is a need for referral. Praying with them, supporting them. They can refer staff members for further support.” (Ginger)*

There were also negative reactions regarding counselling services for caregivers.

*“I don’t know how to put it because she just came in and asked you how are you now. How do you feel. All those things and write the things down. There’s nothing else she’s telling you. It’s something like that...I really don’t know because it really doesn’t help nothing mos. I talk there’s nothing like is going to improve...There’s nothing mos is helping me, it’s just talk.” (Vundo)*

Drentea et al. (2006) and Spiegel and Kimerling (2001) define counselling for caregivers as social support, whereby the caregiver feels free to express emotions regarding their work and other issues. Counselling can also be a form of

psychological support for caregivers, which can in turn benefit the children (Mittelman 2005).

#### **4.2.3 Impact of existing support for caregivers**

The support provided by NPOs impacts directly on the work done by caregivers and on their morale. Such support determines the commitment of caregivers towards the organisation and the relationship that caregivers have with management.

##### **4.2.3.1 Type of commitment to the NPO and relationship with management**

Caregivers stated that they are committed to work with the organisation because of the type of support and respect they get from management.

*“...I like my organisation they look after me the time I was in hospital. I did not expect that. I came back and [the director] said you can sleep in your bed with your children... The organisation all of the people they were in and out of hospital. I still got my job. They treat me like a family...” (Dorothy)*

*“...I’m still fine here at [the organisation] because of their help when I need them. If they didn’t go for that I have to leave for a long time ya. But since they respond if I phone and tell them I’ve got this problem and this, they really jump in. they jump and really help me. But really I’m feeling good and I feel free and they didn’t nag me. Sometimes they not just came here and they came without, like they phone... They respect my privacy...” (Vundo)*

The above statements reflect the Ubuntu principle in which caring and support is shown by the NPO for its caregivers who in turn show loyalty. All The caregivers in this research have been with their organisation for three years or more. This shows commitment to the work done and to the NPO. It is likely that the support given to caregivers impacts positively on their willingness to commit to the organisation and allows the NPOs to retain their staff in the long term. Similarly, staff retention was demonstrated in a study by Riggs and Rantz (2001) whereby group activities were performed to address the issues and needs of staff. This support given to staff of a nursing home served to retain its staff.

#### 4.2.3.2 Personal satisfaction

There is clearly a positive impact on the work done by caregivers due to the support they get from the NPO they work with. This positive impact is reflected in the morale of the caregivers and in the lives of children. In the interviews, caregivers have expressed personal satisfaction related to the work done.

*“I think the best day is when children are out and come back and say you know you have a great input in my life...when they move to another house they will come back and say aunty although you do this and this I will remember...”* (Petro)

*“what makes me happy is the way the children have improved their standard at school from the way we have been helping like doing their homework and stuff. Some of them that went home already those were doing very well and the things that makes us happy is when they get a family or a foster home... Even when we meet those who used to live here there growing up that’s makes us happy that our job is doing fine, some of them are 15 years old when they came here there were so young.”* (Anna)

*“...we are running a really good program here...we have people coming from outside here to help studies and stuff...I love my job because there is successes... You got kids studying at universities...”* (Ali)

The statements above reinforce the findings of Fukkink and Lont (2007) who showed that specialised training in childcare makes a significant and positive impact on the quality of care provided by caregivers. Caregivers also indicated feeling good about successes of the children. This is in line with findings by Orner (2006) indicating that caregivers who felt supported linked it to an improved psychosocial status.

Moreover, it is important for caregivers to have their human needs met to feel fulfilled and be motivated to go on with their work. As per Max Neef’s (1991) scale of fundamental human needs, caregivers, as with any human being, require subsistence, protection, participation, affection, creation, leisure, freedom, identity and understanding. The different types of support given by the NPOs attempt to fulfil such needs. Therefore, as long as the NPO is able to provide and facilitate these needs at work, the experience of caregivers will be positive.

When the children come back to the caregivers after many years to express gratitude and show love, they are fulfilling the need of affection that caregivers have. When the NPO shows respect for the privacy of its caregivers, it allows caregivers to feel understood and respected, fulfilling the need of understanding. It also allows them to have some individuality in how they run the homes or cottages, therefore fulfilling their need of identity.

#### **4.2.4 Challenges experienced by caregivers**

Caregivers reported on the issues they have been facing through their years with the NPO. The difficult situations mentioned were categorised as challenges with children, challenges with management, issues with maintaining a work-family life balance, safety issues in the workplace, financial issues of caregivers and challenges related to the rights of caregivers.

##### **4.2.4.1 Challenges faced with children**

All caregivers had experienced challenges with children at one point or another in their work. The challenges faced by caregivers with the children at work included dealing with children with behaviour issues, being responsible for many children at a time and dealing with different types of children at a time.

*“To look after the child is not a fun, it’s not just like a fun. You must know what you are doing... I can’t say I don’t know why your child is like this.. So I must always be awake you know. So I can’t say I’ve got no challenge because I am always scared, these are not my children. I’m at work, I must look after them, they mustn’t get hurt...”* (Dorothy)

*“When you have a child that is always back chat, then it is difficult to work with, or don’t want to listen. If you tell the child go to your room and please stay there because you were naughty or something...”* (Petro)

*“...I think it was before Christmas, I did not know the children well, I was just starting to build the relationship with them and I believe as they didn’t know me well they also take chances. So this specific night the girls became unsettled because they wanted to go to the dance, which is not allowed since they are placed in our care by*

*Court. So that night they started to toy-toy, singing, banging and I didn't know how to respond, how to approach them since it was my first incident with them..." (Jenny)*

*"...There was one child he came to me and he was not talking. He was like talking like animals like those who just imitate the animals, he was not talking proper like a person...I was really scared, like what am I going to do... How am I going to do with this child and this child has also Down's Syndrome and I never met a child like that..." (Vundo)*

*"...here you are working with many children, 7 per cottage so you have to look after the 7. And they are also different... So are work we having challenges because of some them, their backgrounds, it's very different." (Besh)*

*"I don't think it is easy work because you have 10 children and it's not like a combined group. You have to , as I always say, you have 1 boxes with 10 children in. so you have to see your children like this one is this and this one is... and you have to work with the individually with each one..." (Petro)*

The caregivers interviewed for this research study each take care of six to ten children at a time. Research by De Schipper et al. (2006) indicated that the lower the ratio of child to caregiver the higher the quality of the interaction between the child and the caregiver. De Schipper et al.'s (2006) study showed that a 3:1 ratio was better than a 5:1 ratio. Therefore, it is in the interest of the children that the ratio of child to caregiver is kept low, certainly much lower than 10:1.

An issue was raised about children having problems to adapt when they move from one organisation to another. This problem results from the fact that NPOs differ in their practices and internal policies. For the caregivers, this is reflected in the behaviour of children who come from other organisations.

*"All the organisations they don't operate the same way...in our organisation we are mostly supervised. Whereas the others they...got people who assist the children by helping with the chores with the homework whereas here we just supervise the children. When the children go to another home or exchange homes, it is whereby you*

*as child care worker sit with a problem...The child cannot adopt that system easily because of the different set ups of the organisations...” (Jenny)*

There might be a need to have basic standards of operation for NPOs involved in child care. This could create more cohesion in the work done and allow for better collaboration between NPOs, who could share resources and facilities.

#### **4.2.4.2 Challenges faced with NPO**

The caregivers talked about the difficulties they were facing with their NPO and the management of the organisation. Issues raised by caregivers included lack of or miscommunication with management, lack of consultation by management regarding decisions taken about the caregivers and their work, practical issues such as transport problems and issues about internal policies of the NPO regarding the family of caregivers.

There were also negative feelings expressed by some caregivers regarding the issues they were facing with the management of the NPO. The latter was criticised for imposing decisions on caregivers rather than working in consultation.

*“...the happiness isn’t much because...management, the style of doing things they would do things without a proper consultation... My partner was sent to another house... It was not discussed with her. No orientation. They say that’s what the program needs...what worries me the most is that your moral, emotions, everything is very low.” (Ali)*

*“We had 12 child care workers and now it’s 10 because they [the NPO] are not employing anymore. They made financial decisions for the next five years that they aren’t going to employ more people and they make those decisions not considering the effect it would have on us [caregivers]. So where the senior would have more flexible hours, she now has to go more into a house, more hours in a house but the same responsibility is still the same... but they haven’t changed the responsibilities. So they don’t care...I can work 16 hours a day and then I have to go in the next day and another night, another night...the hours are long...” (Amy)*



*“...the children are sick, sometimes during the night and I have to take them to hospital, like that sitting with them there. And every month I have to go to like to fetch their tablets in hospital. Wake up in the morning after they are gone to school and to also go, maybe I went out here 8.45 a.m. and then came back 4.30 p.m. because hospitals are always full...when it comes to that it's really hard.” (Vundo)*

*“...our boss told me and others...even though you live so close, your child can't come, to me, she must go. Even though I am living three blocks away... Our kids and my kids are not allowed to come because our management see it as them interfering with the program. So, it was quite difficult to explain to my eight year old... Why can't you talk to me, she said. I had to chase her away. This is the kind of experience I have.” (Ali)*

Some caregivers expressed deception in the NPO they worked with.

*“...when I came to this place they said the reason why you earn so little it because you are living on the premises...the house, the electricity...they brought the impression that you are lucky to be here, but if you look at the whole picture then you will see there at times when you finish at 10 p.m. and you begin at 6 a.m., by that time you are actually on duty...” (Ali)*

*“...everyone is fed up the way the communication here at [the organisation], everything messed up so everyone's going to do what they are supposed to do and that's all and its all insane because who is suffering now the children not us.” (Mpha)*

There might be is a lack acceptance of the conditions of work from some caregivers. It may be due to a lack of information provided by management about the actual material support that is given.

Navaie-Waliser et al. (2002) found that there could be adverse effects on caregivers and on the patient, that is the child, if proper support and preparation is not given in caregiving work. This indicates that it is essential for the management teams of NPOs to discuss and plan any changes in the work with caregivers before implementation.

#### 4.2.4.3 Work-family life balance

When asked about the issues of balancing their personal family life and their work life, caregivers referred to the challenges faced throughout the years. This issue was of particular concern for caregivers who had young children at home.

*“It was not that easy. But I had someone come and live with me to take care of them when I left home early for work and my husband. And at night we came in late. So the person was actually staying there with us to take care of the kids.”* (Jenny)

*“Sometimes it’s difficult because when I’m night shift that means I don’t see my kids at all because by the time I have to come to work they are still at school because I have to catch an early train.”* (Wewe)

*“...when I go into my flat, then my daughter listen daddy, you know, I saw you today, the kids were stressing you out and it’s okay for you that they stress you out when you come into the house you don’t have much time for us. It was exhausting for me.”* (Ali)

The female caregivers participating in this research study, report having to sacrifice time with their own children at home to work as caregivers taking care of other children. This can be compared to the situation of women health care professionals studied by Ward-Griffin et al. (2005) who face physical and mental exhaustion. Findings of this research study indicate that male caregivers can also face such exhaustion. In his comment, Ali describes that he feels exhausted by the dilemma he experiences with his own children and his work.

For some caregivers, it was common to have their children stay with a family member in another area of South Africa while they worked.

*“...I didn’t find nothing wrong because for a long time I’m here in Cape Town...I was working before...My child was growing there by my aunt and was younger than that age and there is nothing wrong because on holidays my child is visiting me and also if I take leave I also go to my child. So there is no difficulties.”* (Vundo)

Others referred to issues about separating their family home with the residence at work. Because of the nature of the work of a caregiver, caregivers stay long hours with the children and the workplace becomes a second home.

*“...your mindset must be this is work, this is home. My house things is like that and this is work. I always work like that. My things are different. I don’t compare my house to work. It’s two different things for me.” (Petro)*

It is clear that the work of caregiving is demanding for both male and female caregivers. Although some caregivers do not have children or have family members who take care of their children while they work, most caregivers report that due of the nature of caregiving work they have to forego a lot of time with their own family in order to work.

#### **4.2.4.4 Financial issues**

Caregivers reported on their financial constraints because of the low salaries they earn and the increasing cost of living. Some stated that they cannot afford a home of their own with their salary and that they found it hard to make ends meet each month. Some caregivers also reported using from their own money to sustain the children they were taking care of.

*“I think so because we have a big responsibility on us to look after other people’s children who has problems with eh, who struggle with no work and finances. So I really think we, all of us, who are caregivers and working with children, I really think... there is other things that can be done...like our salaries because of all the things that go up and up and up. Because we are lucky in this children home to live here and get all the things and because there is other children homes they [caregivers] don’t live there and because if they [the NPO] say we must live outside for some reason, because [this area] is very very expensive and I saw a like a flat and it’s like a small flat it’s R7000! Where on earth! We can’t afford that.” (Petro)*

*“... It’s a pity I don’t know how much a caregiver is supposed to get. It’s a pity but here I can’t say it’s enough, because at the end of the day I’m using my money...You know my petty cash is only R1500. I must buy the electricity, I must take the children*

*to hospital, I must buy the snacks, I must buy the bread... It's not enough for six children for one month... They [the NPO] buy rice, everything... But you can't say it's enough for the children. There are no snacks you know.*" (Dorothy)

The above statements reveal that caregivers are in a state of worry because of lack of money and Prachakul and Grant (2003) indicated that being anxious about money related issues could lead to depression, therefore affecting the health of caregivers. It is also clear that two of the three types of economic costs referred to by Guberman (2010) are experienced by caregivers in this research, namely, caregivers experience employment related costs due to a low salary and out-of-pocket expenditures when using their personal funds to make ends meet at work.

#### **4.2.4.5 Physical safety issues**

The caregivers were concerned about their physical safety within their work environment. They expressed uncertainty and fear about certain situations that exist in their work and that could endanger their lives.

*"There is a right for safety. But in the work situation, like childcare you don't feel safe because there is nobody who can protect you in terms of the work environment."* (Jenny)

*"For me as a caregiver what I would want is for at least once a month or two months go to see the doctor because we are working in a dangerous work. Like now our children are HIV positive..."* (Mary Jane)

*"This place is not secured...there is a lot of skollies [gang members] here. Our yards like are eh are low and we haven't got even rubbish bins today. It's the skollies, they just took everything they saw even the pipes... Gangs ya... We need the safety, a safe place, with these children because we are only women here."* (Vundo)

With regards to safety issues at work, there is little reference in the South African legislation pertaining to the rights of caregivers. The Basic Conditions of Employment Act (No.75 of 1997) refers to hours of work, leaves and remuneration of workers and does not refer specifically to safety issues regarding caregivers who work with children and who spend many hours at their workplace. Therefore, this piece of

legislation is not specific enough to protect the safety of caregivers working with children.

#### **4.2.4.6 Rights of caregivers**

Basic employment regulations, namely the Basic Conditions of Employment Act (No. 75 of 1997), apply to caregiving work. The caregivers indicated that they had some knowledge of their work regulations, especially regarding their work hours. They felt it was important that the NPOs respect such legislation and that all caregivers are made aware that their work hours are consistent with the legislation.

*“...the Basic Conditions of Employment came in...you can’t work more than 12 hours... If you are doing a 12 hour shift, you need to have a 12 hour gap between the time you go off duty and the time you come on duty... You also can’t work more than so many days a week...” (Pam)*

As reported by caregivers in this research, there is clearly a lack of policies regarding the rights of caregivers to protection and safety in the workplace.

*“For me, when it comes to the Bill of Rights, we [caregivers] feel hopeless because the children have got I think more power than us. Yes because of their rights they [the children] think they have got more power than us.” (Jenny)*

*“They [legal authorities] should protect us the workers since we work with children because sometimes there can be something you did not do but there is no one to take care cause we don’t know if it’s right or wrong. Someone to turn to when you need something or in case you make a mistake, because you see the children have the social worker but us you see we need someone who can take care of us...” (Anna)*

Similar to what Sen (1999) advocates in his freedoms approach to human development, caregivers view the access to freedoms such as having ones rights respected and having access to a dignified life and having ones needs met as being forms of freedom that are needed for human well-being. Caregivers are demanding that their basic rights to protection and respect are recognised in the workplace.

#### **4.2.5 Type of support needed by caregivers from their respective NPOs**

Caregivers provided insight on what support and resources are needed from their organisation to improve their work conditions and well-being. They stated that it would be a plus if the NPO worked more with government for them to benefit from services offered by the government as well. Caregivers also mentioned the NPOs need to increase their salary, to recognise their efforts, to enable their access to information about policies related to caregivers, to make provision for their physical and emotional well-being, to employ additional staff, to improve transport facilities at work and to allow direct communication by caregivers with the board members and the management team of the NPO.

##### **4.2.5.1 NPO to work with government and private sector**

Many caregivers felt that the NPO they were attached to could work more with government to get access to funds and facilities such as training. Private companies were also mentioned as a means to get sponsorship for activities.

*“All organisation need to involve government so that people get money.” (Saps)*

*“...Like apply from government for learnerships [trainings] or that type of support, financial support. Because it is hard to pay for your own studies just with a single income.” (Jenny)*

*“I know there are a few companies that you can go to where people are there for the care and the caregivers but I think that we need more than that. We [caregivers] don’t need that type of stuff, information, programs, we need physical things. We need money. Give me stuff that I need.” (Ali)*

Cameron (2009) stated that caregivers employed by NPOs or belonging to CBOs and informal family caregivers are bearing the costs of healthcare because the State is failing to provide adequate support in public facilities. Therefore, the State needs to recognise the burden borne by caregivers employed by NPOs at low salaries. According to the South African Constitution (Republic of South Africa 1996), it is the responsibility of the State to provide for the welfare of people. Thus, it is the

government's duty to support NPOs who are doing part of the work the State should be doing.

Given the nature of the non-profit sector, such organisations are sometimes reluctant to collaborate or seek help from government or the private sector. It is also up to NPOs to solicit and obtain support from the government and private companies because the objective is, above all, the welfare of children.

#### **4.2.5.2 Significant increase in salary**

Caregivers have given arguments justifying the need for higher salaries for themselves and for other caregivers. The reasons put forward by caregivers include that the cost of living is increasing and that caregivers, even those living at their work site, have expenses and need to care for their own families. Additionally, caregivers state that because they are employed by NPOs they have fewer benefits than caregivers employed by government. Therefore, they require more financial benefits to pay for things like healthcare, prepare their retirement and even own a home.

*"...not as I don't appreciate the flat and all that we have here. I think it is because the economy is going, the prices are rising and you have to live. I think anyone needs money and it's not because we are greedy or something. It's because the cost of living is increasing..."* (Petro)

*"... Also we need money for the no benefit fund, no medical, no subsidy house, because you need to find your own house..."* (Saps)

The supervisors of caregivers interviewed stated that if more funding was available, a salary increase or bonus could be an option as they agree that caregivers deserve more remuneration for the work they do. However, the argument that the caregivers presently employed by NPOs would no longer get the jobs as people with higher qualifications would apply, if salaries were higher.

Moreover, as per the human needs approach, it is important for caregivers to be able to sustain a living by meeting their basic needs. Max Neef (1991) writes that subsistence is one of the fundamental human needs. As indicated in the above quotes,

getting a minimal salary for the work they do, does not allow caregivers to live properly.

*“If the salaries went up the people doing the jobs now would not get the jobs. Because people with higher qualifications would not get the jobs. So it would be good for the children, it would be good for the people who are employed but it would be bad for the people, some of who may not be very well educated but are excellent in the actual caring.” (Pam)*

The above statement by Pam indicates that if higher salaries were offered for the job of caregiver, people with higher qualifications would be applying and the people actually working as caregivers might not get the jobs. Thus, providing a salary increase without training might be detrimental for caregivers presently employed by NPOs, as many of them have a low level of education. It is only through training and capacity building of caregivers, that the latter will be able to sustain their jobs despite increases in the salary level.

#### **4.2.5.3 Acknowledgement of work done by caregivers**

The caregivers expressed a need for their work to be valued and recognised by their organisation. They expressed the need for recognition of efforts made through verbal acknowledgement and rewards such as a promotion.

*“...the thing that is the best for us is that they [management] see what we [caregivers] do and that they appreciate what we do for the children and we are the people that work with them everyday. I think it’s important that they recognise what we do... I think if they write a letter or something to us they always say thank you for the work you do. (Petro)*

*“And the other thing is when I arrived at [the NPO] I was just a carer but now I have improved my standards now I am a team leader, supervisor which means my standards have improved now and to get our manager came to tell us guys you are doing nice which makes our job easier and happy.” (Anna)*

*“If someone did something appreciation is very important even if someone did not do a big thing if child care workers can be appreciated more.” (Besh)*



Similar to the primary caregivers in Orner's (2006) study, the caregiver in this research study feel that acknowledgement of work done can be a support, especially by people in the same line of work. It is interesting to note that caregivers have expressed a need for appreciation in forms other than monetary rewards.

#### **4.2.5.4 Access to information regarding policies related to caregivers**

With regards to policies and regulations regarding caregivers, such as registration and work conditions, caregivers referred to the NACCW training modules they were doing as being a first step to get official registration as child care workers. Others were not aware of such issues and only one caregiver stated that she was registered with the NACCW.

*"I don't know. We completed the application forms, police clearance. We were promised after this training thing we would be seen as officially....maybe there is more general maybe...another thing is not to be recognized and earning a small salary is I don't think motivate you in a way to make you feel it is worth being a child care worker."* (Ali)

*"Eh to register to government... Yes it's very important... Because you will get everything... like when you pass your family can get everything. Like you work on a contract, building a house. When you are building a house when you have an accident, they'll pay."* (Saps)

*"...capacity and resilience broadening [is needed for caregivers] because things are constantly changing. Things that are happening, children are changing, they [caregivers] need to keep up to that pace. And they have to be capacitated according to that. Laws are changing they need to be kept up to speed about that."* (Ginger)

Findings indicate that caregivers have very limited information about the policies concerning their rights and conditions of work. They have demands but seem to not really look for the appropriate information to be able to take action and state what they need. According to the Basic Conditions of Employment Act (No. 75 of 1997), it is the responsibility of their employers, the NPOs, to keep them up-to-date regarding policy changes affecting their work and their lives.

#### 4.2.5.5 Provision for physical and emotional well-being of caregivers

Caregivers participating in this research study take care of up to 10 children at a time and it is highly demanding on their emotional state and NPOs do not want their caregivers to be ill or face fatigue and not be able to work. As such, the NPO recognises the need to invest in the caregivers' when resources allow it. However, if resources allowed it both caregivers and their supervisors stated that it is essential for caregivers to relax and be cared more often.

*"...what I would want very much is...health things like gloves and things. The ones we get are one, two, three and finish and then you start to work with empty hands...sometimes when a child is bleeding something like that...even the medication like the flu medicine if a child is sick got a headache or things..."* (Mary Jane)

*"Like yes someone from outside to encourage us to talk, work, like motivating and also prayer is also widely important..."* (Saps)

*"I think they [caregivers] need maybe on a quarterly basis to have some kind of pampering...sometimes they need the physical relaxing. Yes we try to deal with the emotional one but I think...for me I feel they are, eh yes we look at the Basic Conditions of the Employment Act but maybe their days of rest might not be enough. And things like a massage, they need that, but we don't have that. Just to relax physically but we have tried to have some time. When we do outings we do games and play...and just thresh out there."* (Ginger)

*"Making sure they [caregivers] have time off, listening to all their concerns and just being there for them and picking up the pieces and to listen and observe, see when things are going wrong."* (Jane)

Various studies have found that caregivers are highly prone to health issues due to the nature of their job (Coe and Van Houtven 2009; Liu and Gallagher-Thompson 2009; Lynch et al. 2009; Ho et al. 2005; Prachakul and Grant 2003). It is therefore logical that both caregivers and their supervisors think it is necessary for caregivers to have access to stress relievers and programmes that will favour their physical well-being.

#### **4.2.5.6 Additional staff**

Findings have indicated that caregivers take care of six to ten children at a time. Caregivers have indicated that there are situations that arise where they feel that having a co-worker could help them to do a better job with the children.

*“I think more staff, especially on a night shift. Because the night shift when anything happens you can’t leave the house like that. A day shift at least there are people in the house like volunteers is coming and so. But the night shift you’re alone, you cannot leave the house and then you sit with a crisis. It did happen and it is thus whereby they can assist us, support us.” (Jenny)*

*“In the afternoon with homework. We get volunteers from but not a regular basis. We have a person who help us but it is difficult when all ten have homework. That is one of the most important things that we want help with.” (Petro)*

The NPOs also reported having limited resources and that it might be better to first invest in capacity building of caregivers to avoid the cost of additional employees.

*“Not necessarily. Because we are talking of adding the cost, you need to first build the capacity of that person unless they cannot cope even at that level. Then you can look at what interventions. That’s when we look at maybe the supervisor to step in at times to assist.” (Ginger)*

#### **4.2.5.7 Transport facilities**

There were demands for transport from caregivers of only one of the NPOs. The caregivers stated that the lack of transport to take children to hospital or to take staff home when caregivers finish work late lead to precarious situations that made their work more tiring and risky.

*“...like sometimes we need transport, really. Sometimes, it’s raining and the children is sick. There is no transport, you wait and wait for a long time for the ambulance. You haven’t got the money to take the car... I wish you can get something like the cars or like that to help us.” (Vundo)*

*“...when you work late...especially when you sit with an incident... You can't handover that incident to the next person. You have to sort it out...you have to report the child missing at the police station and it's almost time to knock off...now you have to go by home on your own. If you don't have money to travel be taxi or whatever, then you are stuck... If they can assist us maybe in arranging transport to take you home.” (Jenny)*

According to the Basic Conditions of Employment Act (No. 75 of 1997), transport needs to be provided for caregivers when they work later than 6.00 p.m. However, the case may be that the NPO cannot afford transport for caregivers due to its limited funds.

#### **4.2.5.8 Communication with the management and the board of the NPO**

There were reports from different caregivers of the four NPOs included in this research study that certain work issues were decided upon without consultation from the management team. The caregivers reported that there is a need for more communication with the management and board of the NPO.

*“...We [caregivers] would like to sit with them [the management team and board members] in a proper meeting where we are allowed the platform and the time to actually tell these people what it is what I am unhappy about, can't you guys give us more money, this is what the child care is all about. We would like to discuss things like this with them but somehow it's not possible.” (Ali)*

The children are put in the direct care of the caregivers who make decisions everyday pertaining to the well-being of the child. When NPOs impose decisions upon them without clearly explaining the full picture it is similar to restricting the decision-making power of caregivers regarding their work. This way of proceeding is contrary to the people-centred development approach which advocates for people to play an active role in defining their own development. Davids et al. (2009) explain that people centred development allows people to increase their capacities and mobilise resources to improve their quality of life and that of their community. This implies that it would be in the best interest of the NPO to have caregivers participating actively in decision making process.

#### **4.2.6 Support needed from civil society**

Caregivers are aware that the work they do is very valuable to the lives of children and that they are part of a wider system that works for the well-being of children. Referring to the ecological systems approach as given by Bronfenbrenner (1979), the caregivers work in the NPO can be seen as a micro system that connect to a wider macro system represented by national legislations and policies, such as the Children's Act (No. 38 of 2005), through a mezzo system that is civil society, namely the NACCW.

As the micro, mezzo and macro systems influence each other, caregivers feel that they need support from the wider components of the system to improve their work conditions and become more efficient in their work.

##### **4.2.6.1 Role of the NACCW**

The caregivers referred to the NACCW as being non-governmental and stated that the training provided was relevant to their everyday work with the children. There was the idea that the NACCW had power to influence issues relating to caregivers.

*"I think the NACCW, I think...they have to fight for us with the government to, eh because I don't think there is not so much from the government in childcare. I'm not talking about the courses now, I'm talking about the personal life things and eh our salary and that things I don't think there is much."* (Petro)

The NACCW (2011) advocates for the development and health for children and one way of doing so is by providing training for caregivers working with children and youth. There is no indication from the literature review that the NACCW is fighting for the rights of caregivers or to improve their well-being.

#### **4.2.7 Support needed from government**

The demands of caregivers for government did not relate specifically to the Department of Social Development or any other specific government departments but broadly to the South African government.

#### **4.2.7.1 Policies related to the work conditions of caregivers**

Caregivers stated that government could definitely help them more in terms of their conditions of employment. Many spoke of having policies relating to conditions of employment and to retirement benefits.

*“I think the government can help us to provide us will benefits first of all, like retirement funds. It’s not nice to finish your work and you have nothing just your salary and now you got children to look after.”* (Florence)

*“...I think the government can help us about the timing you know. Like not more hours little money, you know sometime you can get stressed out like when a child says mummy bread, you can just smack a child because you are stressed out.”* (Mary Jane)

Some caregivers are foster mothers to the children and they are able to care for the children with the foster care grant given by the State. However, the process of applying for the grant is cumbersome.

*“Sometimes things take long with the grant and they [caregivers] get very very frustrated with that so and the DSD makes it difficult for them to get the grant and they have to work hard.. the DSD should improve...they should just make the whole process easier for them...”* (Jane)

Clearly, the State and more specifically, the (DSD) has a role to play in the welfare of caregivers. However, for this to happen, the State and the DSD needs to acknowledge the contribution made by the non-profit sector in childcare and related issues. Since this information is not presently available, this is difficult.

#### **4.2.7.2 Increase capacity building opportunities for caregivers**

Caregivers stated that the government could contribute to organise and fund more training for caregivers. Information collected through this research study indicated that some NPOs get funding for the training of their caregivers.

*“Have more workshops, because we do attend like workshops but I don’t know if it is government. We attend the workshops like parenting skills but that everybody can go*

*at the same time or whatever. There is some lack in parenting which I think it would be better if each one can have that training in order to make your work easier.”*

(Jenny)

*“The training is, we know but we need it, the theory. Most of the things that we work with.”* (Petro)

The caregivers expressed a need to be constantly empowered with training so as to be relevant and up to date in their work. They feel restrained by costs and what is being provided to them is limited. With reference to the people centred development approach (Davids et al. 2009), caregivers wish to be empowered to be sustainable in what they do and therefore contribute to their own development and that of the children in the long term.

## **Summary**

The main themes and categories extracted after the analysis of the interview transcripts reflect the ideas presented in the discussions above. The findings reflect that caregivers working with NPOs based in Cape Town do get support from their organisation, namely in the form of social support from colleagues, capacity building opportunities with the NPO, financial rewards, occasional time off and recreational activities and access to services (such as psychological support) that might be provided by some NPOs.

However, a number of types of support that the caregivers would like to have but do not yet have were also discussed. These include more inclusion of government services and policies in the work done by the NPO so that the caregiver benefit from some government protection, uniformity in the policies relating to caregivers, increase in monetary gains so that caregivers feel more financially secure, increased support to have access to information regarding the rights of caregivers and knowledge about policies relating to caregivers, specific provision by NPOs to cater for the physical and moral well-being of their caregivers and more transparency in the management of affairs between the management of the NPO and the caregivers, among others.

The support required by caregivers and the issues they raised and that were discussed above reflect the views of the caregivers and caregiver supervisors. Thus, the next chapter provides recommendations being addressed to the different stakeholders in the child-care and NPO world to diminish their challenges by providing them with the support they need.



## **CHAPETR 5:           RECOMMENDATIONS AND CONCLUSION**

For action to be taken to attend to the different types of support needed by caregivers and the challenges they face, specific recommendations were made for specific stakeholders, namely the NPOs employing caregivers, caregivers themselves, civil society, the Department of Social Development and the private sector. The recommendations below link directly with the research questions

### **5.1 Recommendations**

#### **5.1.1 Recommendations for NPOs**

The recommendations are for the management team of the NPO, namely the director and the caregiver supervisors. The recommendations are also relevant to the board of the NPO depending on the extent to which the latter is involved in the decision making process of the organisation. It is recommended that:

- The NPOs need to precisely define and explain their role to the caregivers before caregivers begin to work with the organisation. The caregivers need to be told about the challenges involved in the work, such as the number of hours spent with the children, the different roles and responsibilities the caregiver will have to take up and the potential issues that may arise with the salary and daily burdens of running the households with the children. The point has to be made that the job includes being able to handle unforeseen circumstances that will arise due to the nature of the work. This will result in caregivers being better prepared emotionally to deal with issues that come up. This may help to limit misunderstandings once the caregivers take up the job;
- Findings of Navaie-Waliser et al.'s (2002) study indicate that the management teams of NPOs need to work hand in hand with their caregivers to make decisions regarding the daily routine of the caregivers and of the children, as well as consult caregivers on issues that will affect their work in the short term, medium term and long term. Such issues can include matters relating to the children, to the structure of the home and to the running of the organisations. This type of partnership work

between the NPO and the caregivers will help to avoid adverse effects on the caregivers and, in turn, on the children;

- NPO needs to make sure that its caregivers are trained and able to work with more than one child at a time. Additionally, NPOs need to employ sufficient staff so as to limit the number of children per caregiver. Research (De Schipper et al. 2006) has shown that a lower number of children per caregiver does allow for better quality care to be provided. NPOs need to recruit more volunteers and make efficient use of these volunteers to help caregivers in daily tasks such as helping children with homework. Despite having training and experience, caregivers stated that they need help to take care of a group of children at a time, especially for issues such as schoolwork;
- As per the Basic Conditions of Employment Act (No. 75 of 1997), the NPO needs to make sure the rights of caregivers and other related policies are made accessible to caregivers at the workplace. This means that a written or printed document has to be kept visible at the caregivers' workplace at all times;
- Another way of providing information to caregivers could be for the NPO to provide staff with access to online support through a website designed specifically for caregivers. This would require additional resources from the NPO but online support has proved to be efficient (Perron 2002). Online information has proved to help caregivers deal with emotional issues as well as practical issues arising with patients.

### **5.1.2 Recommendation for civil society**

It was clear from the research findings that there is a lack of mobilisation for caregivers from civil society (such as NPOs working with caregivers, caregivers themselves and the community benefiting from the services of caregivers). Apart from the NACCW that focuses on training of caregivers to improve the quality of care provided to children and youth in South Africa, there was no sign of a NPO, or CBO, or collective efforts by caregivers through a union that acted as a voice for caregivers.

The following recommendations are made for civil society to mobilise for caregivers:

- There is a need for caregivers to establish an organisation that represents them. It is the responsibility of caregivers to step up and mobilise to fight for better conditions of work for all caregivers employed in the non-profit sector. Issues that need attention include the protection of caregivers in their work environment; retirement benefits; healthcare and health benefits; additional days off work due to the nature of the work (beyond and above what is prescribed by the Basic Conditions of Employment Act No. 75 of 1997); and registration issues;
- It is the responsibility of organisations such as the NACCW, who work with caregivers to make sure caregivers also learn more about their roles and responsibilities and about the work dynamics and relationships with management and colleagues. That is, caregivers need to be further educated about their multiple roles in the workplace and in society, such that they do not exist only in their workplace and cut back completely on social life. Innovative means need to be put in place to facilitate the access to information and support for caregivers. Such innovative means can include better use of technology for caregivers to share information;
- There is a need for NPOs working with children to come together to develop common basic standards of operations for NPOs involved in child care. Thus, NPOs would be able to compare their performance in terms of quality of care provided and learn more from each other. This could also be the opportunity to share resources and organise activities in collaboration with others on a regular basis. Working together and sharing resources may help to reduce costs in the long run.

### **5.1.3 Recommendations for national government**

The caregivers stated that they were facing challenges related to the absence of policies protecting their safety at work, their rights in the workplace and that their work was not remunerated well enough. The following recommendations are made for the different South African government departments which can take action to define policies related to caregivers:

- There is a need for common guidelines for work conditions of caregivers to be provided to NPOs involved in care work. The common guidelines would serve as a baseline indicating the essentials and standards that need to exist in an NPO to provide optimum support to caregivers it employs. It is the responsibility of the Department of Social Development (DSD) to work towards such guidelines and to make them official;
- The DSD needs to define policies that reflect the conditions of work of caregivers specifically. Such policies need to make provision to ensure the physical safety and health safety of caregivers at work. The policies also need to provide for medical and emotional support for caregivers on a regular basis;
- The DSD needs to have regulatory policies regarding the minimum salaries for caregivers. Given the nature of the work of caregivers and the overtime hours they have to do, a minimum amount per hour is suggested. It is very important that this benchmark amount is defined through a common agreement among all parties relevant to the caregiving profession, namely caregivers employed by the public, private and non-profit sector, as well as employers of caregivers from the three stated sectors;
- The DSD and the Department of Labour need to ensure that caregivers who are, or have been, employed in the non-profit sector also get retirement benefits paid by the State based on years of service. The justification is that caregivers employed in the non profit sector have contributed to the welfare of the population and have often done so at minimum wage. Given the limited resources of the NPOs which employ them, retirement benefits for caregivers can be a good way for the State to support such NPOs;
- The DSD needs to make trainings more accessible to caregivers employed by NPOs as the non-profit sector contributes to achieving national goals such as poverty alleviation. It is not sufficient to fund caregivers for training about child care. The DSD needs to partner with the Department of Health and other relevant authorities, to design and provide training that can help caregivers improve their life skills. The DSD needs to facilitate training for assistant caregivers as per the Isibindi model and the Ubuntu model so as to ensure commitment to care work.

Although some NPOs are employing assistant caregivers to help out caregivers, there are complaints as to the efficiency and commitment of the assistants. It would benefit the caregiving profession in the long term if caregiver assistants were properly trained and could later be promoted to full-time caregivers.

#### **5.1.4 Recommendation for researchers and all stakeholders concerned**

This research study revealed that much vital information regarding caregivers and the work they do was not available due to lack of research in South Africa. The following recommendations are made for further research:

- There is an urgent need to have statistical information on the contribution made by the NPOs involved in childcare and employing caregivers. Their contribution to achieving national goals needs to be measured and recognised for the State to realise that it has to support NPOs more strongly. Additionally, the costs borne by caregivers employed by NPOs and the NPOs themselves needs to be calculated for South Africa. This is important to determine what the South African government would have to contribute if NPOs were not doing the work;
- There needs to be further research about the ‘need for appreciation of work done’ felt by caregivers. Research would provide insight on how to reward caregivers in forms other than monetary. This could be very useful for NPOs as resources are scarce in the non-profit sector;
- The relationship between financial constraints and anxiety or health risks needs to be explored further. Thus, a strong case can be made to justify that a significant increase in salary is needed for caregivers. Although some research indicates this, a wider scale research study pointing to the adverse effects of financial constraints and poor remuneration on caregivers and their work can help to improve the salary level of caregivers.

## **5.2 Conclusion**

This research study indicates that caregivers do feel supported by the NPOs they work for. However, they still face challenges due to the large number of children they take care of and they require additional assistance to do a better job. All caregivers

indicated that when they face daily issues at work, they can turn to the management team of the NPO or to the social worker. However, with regards to challenges they face regarding their conditions of work, caregivers did not seem to know exactly who is responsible of the bigger issues and who can improve their situation. Although findings of this research study cannot be generalised, there is an indication that there are similarities in the challenges faced by male and female caregivers.

Clearly, there are solutions to the challenges faced by caregivers in South Africa. The relevant stakeholders need use the recommendations of this research and work coherently together to regulate the situation of caregivers in the non profit sector and provide them with conditions of work that reflect a higher status and standard of living in South African society.

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## **APPENDICES**

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## Appendix A

### Interview schedule

#### Profile of Respondents:

CAREGIVER PROFILE	DIRECTOR PROFILE
Name/ Nickname:	Name/ Nickname:
Gender:	Gender:
Age:	Name or type of organisation: Location:
Name of organisation and location: Or Type of organisation and location:	Years as caregiver supervisor in the NPO:
Years as caregiver:	Number of caregivers in the organisation:
Hours of work per week: Number of days per week: Day shift/Night shift:	Number of clients/patients the NPO covers:
Place of stay:	Region/ Area covered by organisation:
Marital status:	
Children:	
Last grade passed in school:	
Stipend/ Salary:	

#### QUESTIONS FOR CAREGIVERS:

##### A. Understanding the work of caregivers and their challenges

1. Please tell me a bit about you. (Profile, your age? And where you stay?)
2. Please tell me about your work (What tasks do you perform as a caregiver?)
3. Can you describe a typical work day for you?
  - How do you come to work and leave the workplace?
  - Did you choose the time you work/ number of hours you work?
4. Can you describe a good day at work? (the most rewarding experience at work?)
5. Can you describe a bad day? (the most difficult experience at work?)
6. What do you prefer about your work as a caregiver?

7. And what do you find challenging?

**B. Learning about the types of support caregivers get access to in their work context**

1. Can you please tell me a bit about the organisation you work with/for?
2. How did you start to work with this organisation?
  - Why did you choose this organisation?
  - Did you get training before starting the job? (If so, can you give details about the training?)
3. How do you feel about your job as a caregiver with this organisation?
4. In your opinion, how does this organisation support you in the work you do? (What are the facilities the organisation provides for caregivers?)
5. How do you feel about the status of caregivers in South Africa?
  - Do you know about the policies government has for caregivers in South Africa (regarding registration and training of caregiver)?
  - What do you think about the measures and policies government have for caregivers in South Africa?

**C. The impact of support given on the work of caregivers**

(Based on what the caregiver gets as support,\* such as transport to and from work, stipend or salary, co-workers, medical coverage, training or skills development, counselling services, crèche service, overtime pay, mobile phone/airtime, ....)

1. Since when have you been getting this\* type of support?
2. How do you think getting such support\* impacts on you work as a caregiver?
  - If this support\* were to be cancelled/removed, how do you think this would impact on your caregiving work?

**D. The support that would be needed to assist caregivers in their work**

1. What additional support would you need to assist you in your job?
2. According to you, who is responsible for providing the support you mentioned?

3. In general, for all caregivers, what kind of support do you think is needed to help caregivers in their work?
4. Finally, according to you, in what ways can non-profit organisations in South Africa support caregivers?

## **QUESTIONS FOR CAREGIVER SUPERVISORS:**

### **A. Understanding the work of caregivers and their challenges**

1. Please tell me a bit about you. (profile, When did you start working with this organisation?)
2. Please tell me about your work (What are your responsibilities as a caregiver supervisor?)
3. The focus is on the work of caregivers, so can you please describe a typical work day of a caregiver in your organisation?
  - What tasks do the caregivers perform?
4. Can you tell me a bit about the challenges you have faced with caregivers in your organisation?
  - Caregiver: Client ratio? Lack of caregivers? Caregivers quitting the job?

### **B. Learning about the types of support caregivers get access to in their work context**

1. Can you please describe how you recruit caregivers for your organisation?
  - Does the organisation offer training before the caregiver starts the job? (If so, can you give details about the training?)
2. In your opinion, how does your organisation support the caregivers in what they have to do?
  - What are the facilities the organisation provides for caregivers?)
3. How do you feel about the status of caregivers in South Africa?
  - Do you know about the policies government has for caregivers in South Africa (regarding registration and training of caregiver)?

- What do you think about the measures and policies government have for caregivers in South Africa?

### **C. The impact of support given on the work of caregivers**

(Based on what the caregivers get as support, \*such as transport to and from work, stipend or salary, co-workers, medical coverage, training or skills development, counselling services, crèche service, overtime pay, mobile phone/airtime, ....)

1. Since when do caregivers get this support\*?
2. How do you think getting such support\* impacts on the work done by the caregivers?
  - If this support\* were to be cancelled, how do you think this would impact on the work of caregivers?

### **D. The support that would be needed to assist caregivers in their work**

1. In your opinion, is there any support that the caregivers of your organisation could get to help them do their work better or improve on the work they do?
2. According to you, who is responsible for providing the support you mentioned?
3. In general, for all caregivers, what kind of support do you think is needed to help them in their work?
4. Finally, according to you, in what ways can non-profit organisations in South Africa support caregivers?

### **E. Closing of interviews and debriefing for both caregivers and caregiver supervisors**

Thank you for sharing and giving your time to answer my questions for the research.

Is there anything else you would like to add before we wrap up?

Finally, how has this interview been for you?

Thank you!

## Appendix B

### CONSENT FORM

Dear participant

The purpose of this study is to find out about the support that exists for caregivers working with non-profit organisations and determine the support that would be required to assist caregivers in their tasks.

The interview you are about to participate in is anonymous, in that you will not be asked to provide your real name at any point during the interview (The respondent can choose to use a nickname or pseudonym).

Any information you will be disclosing will be kept strictly confidential, and will be used for research purposes only.

You also have the right to refuse to answer any question you feel is inappropriate and to terminate this interview at any point during the process. Also there are no 'right' or 'wrong' answers.

Additionally, the researcher promises to provide feedback to participants on the findings and recommendations of the research.

If you agree to the above and wish to participate in the interview, please sign this consent form.

Thank you.

Participant's signature:.....

(Participant's name:.....)

Interviewer's signature:.....

(Interviewer's name: Sandra Sherila Jatoonah)

Date:    /        / 2012